PLANNING AND FORMATION OF CENTRAL ALABAMA VETERANS HEALTH CARE SYSTEM (CAVHCS)

FIELD HEARING

BEFORE THE

SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

HEARING HELD IN MONTGOMERY, ALABAMA, JULY 28, 1997

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PLANNING AND FORMATION OF CENTRAL ALABAMA VETERANS' HEALTH CARE SYSTEM (CAVHCS)

MONDAY, JULY 28, 1997

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 9 a.m., in the U.S. Courthouse, 15 Lee Street, Montgomery, AL, Hon. Terry Everett (chairman of the subcommittee) presiding.

Present: Representatives Everett and Evans.

OPENING STATEMENT OF CHAIRMAN EVERETT

Mr. EVERETT. Good morning. I want to give a warm welcome to the Alabama veterans and interested members of the Montgomery and Tuskegee communities who are here today for this long anticipated field hearing on the planning and the formation of the Central Alabama Veterans Health Care System.

I am joined by the distinguished ranking Democratic member of the full Veterans' Affairs Committee, Mr. Lane Evans from Illinois. He has a major facility integration occurring in his State as well as in the Chicago area. Some of his concerns about that integration process are much the same as mine are here for Central Alabama. They involve planning issues and communications with stakeholders.

And, by the by, the term "facility integration" means the combination of two or more medical facilities into one functional organization to provide a coordinated effort of effective health care. Here in Alabama we have underway the planning for the formation of the Central Alabama Veterans Health Care System.

Just last Thursday Mr. Evans and I were at a joint hearing of the Veterans' Affairs Subcommittee on Health and on Oversight and Investigations in Washington, DC, this very subject. As Chairman of the Subcommittee on Oversight and Investigations, I cochaired that hearing. Mr. Evans and I, as members of the VA Committee with leadership positions, have a constitutional duty to insure that the laws under the jurisdiction of the Committee are properly carried out by the VA, and that veterans receive the benefits Congress has mandated for them. One of the ways we do that is through oversight hearings such as this.

The focus of the hearings in Washington was on the VA's approach to facility integrations generally, and on the Chicago VA

hospital integration. The head of the VA health care system, Undersecretary Kenneth Kizer, and other VA officials testified in that hearing. The same witnesses from the General Accounting Office we have today also testified last Thursday.

In several aspects that joint hearing laid the foundation for today's hearing. The VA in Washington is still defining its guidance to regional network directors on how the integration process should operate, so it is not surprising that questions have arisen in Alabama as well.

We are working with the VA to improve health care for veterans by improving the way facility integrations are accomplished. Specific issues have arisen about planning and the cost benefit analysis for the Central Alabama facilities, and frankly communications with this stakeholder have not been as good as they should have been. I see a willingness on the part of the VA to improve the process and better address stakeholder concerns, and I hope we can move forward from there in Veterans Integrated Service Network 7, the VA region in which Central Alabama is located.

I have spent much of my adult life as a businessman, and that is how I approach these issues. I want to see a real business plan with the evidence that it is operational and the approach, that it actually will save money and improve efficiency. Moreover, I expect to see a plan for the fair reinvestment of money saved from Alabama's veterans in the form of better access to health care. It is not my intent to try to turn this into "Mission Impossible," and I recognize these are not easy tasks. But the stakes are high and many people in Central Alabama have legitimate interests that concern them greatly.

Because of my concerns I did ask Dr. Kizer, the Undersecretary of Health, to halt the integration implementation process until my fundamental concerns about planning issues could be addressed. He agreed to do so, and integration implementation has been halted, but not the planning. Mr. Larry Deal, the VA Regional Director and the VA's lead witness today, has requested that consolidation of surgical services proceed without delay. His reasons to do so, to go ahead immediately, are sound, and the consolidation of surgery will be accomplished as soon as possible.

The General Accounting Office, the investigative and audit arm of Congress, has been reviewing the planning process and cost benefit analysis for Central Alabama, and will testify today on its findings and suggestions for improvement. Also several of our veteran service organizations, The American Legion, the Veterans of Foreign Wars, the Disabled American Veterans, and the Vietnam Veterans of America who so faithfully represent the veterans of Alabama, will present their views about VA health care for veterans at Montgomery and Tuskegee.

Obviously, while veterans are not the only stakeholders in Central Alabama, they are the most important one. The VA exists because of them. I am certain that we have other stakeholders attending this morning, and they are important to me, too. Unfortunately Mr. Evans and I must return to Washington at midday because House votes are scheduled for this evening. Therefore time constraints do not allow opening up any other lines of testimony at this hearing. I welcome all points of view, and if anyone wishes to

do so, please call my district office or write to me. Many people have already called and written, and I appreciate their interest.

As has been reported in the local media, I have requested that the VA Inspector General's Office independently investigate certain whistle blower allegations of mismanagement and misconduct at Tuskegee. I took this action as Chairman of the Subcommittee who has responsibilities of oversight of not only hospitals in this district, but every district in the United States. Of course I have no way of knowing if any of these allegations are true. The IG's Office has advised me that it will take possibly several months to do a thorough investigation because of the number of allegations. I do not expect to comment further publicly until the IG and the VA have had the opportunity to do their work and draw their own conclusions.

I want to make it clear that our hearing today is only about Central Alabama. At this point nobody is proposing that suggested improvements for this integration process should become the model for the rest of the country or be some sort of pilot program. I support the overall objectives of consolidation. It is in the best interests of Alabama's veterans and taxpayers, but it must be done right so that it improves efficiency, provides quality care, and improves access for veterans. It is up to the VA to convince me and our veterans that, based on the planning yet to be done, that those will be the outcomes.

Also one more thing I want to make crystal clear: There is no VA plan to close either Montgomery or Tuskegee. I will confirm that with both the VA and the GAO witnesses. I expect good, efficient management and quality care for our veterans in each and every VA hospital in the country, and I will not be satisfied with anything less. And I think that goes double for our veterans here in Alabama.

I would like at this time to introduce to you a member of this subcommittee who is also the ranking member of the full veterans committee, my friend Lane Evans.

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEEE ON VETERANS' AFFAIRS

Mr. EVANS. Thank you, Mr. Chairman. I am very pleased to be here. I want to communicate to people that I think Terry has laid out the purpose of this hearing very well in his opening remarks. I am here to learn more about the process of integration in consolidating VA facilities, and I believe that we can only carry out that—that planning with the utmost care.

I share your concerns and commend you for taking the time and effort to bring Congress to Montgomery for a few hours this morning, Mr. Chairman, to discusses the integration process here in Alabama. It is very important that we get out into the field and actually hear from people about the way that laws that we pass in Washington actually play out and affect veterans here in the heartland of the country. So we are very pleased to be here.

I want to say that as the number one Democrat on the Committee I very much appreciate Terry's efforts on the other side of the aisle, because he has been very fair to the—the minority of us on

the Democrat side. Not only have I served with him in this position, but I once was chairman of this subcommittee, and he was the ranking member at that time, so we have a good working relationship. We are going to be going out to Chicago sooner or later to carry on this process.

I also want to thank the veterans of the area that have come out today. I know Monday morning is kind of a tough hour for some people to come out, so thank you for joining us; thank you, Mr. Chairman, for bringing Congress to your District; and I look forward to hearing the testimony.

Mr. EVERETT. Thank you very much, Lane.

As I would like to welcome all the witnesses testifying today, I realize some of our witnesses have taken time from their daily lives and they had to travel some distance to be here today. I ask that each witness limit your oral testimony to 5 minutes. Your complete written statement will be made part of the official hearing on the record. I am also asking we hold our questions until the entire panel, if needed, testifies.

And now I ask the first panel to please be seated. Mr. Deal.

Mr. Deal, for the record, is Director of Veterans Integrated Network Service Number 7. And, Mr. Deal, I will ask you to introduce your panel.

STATEMENT OF LARRY R. DEAL, DIRECTOR, VETERANS INTEGRATED SERVICE NETWORK 7, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS accompanied by CARTER E. MECHER, VISN 7 CLINICAL MANAGER, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS and JIMMIE L. CLAY, DIRECTOR, CENTRAL ALABAMA VETERANS HEALTH CARE SYSTEM, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Mr. DEAL. Good morning, Mr. Chairman.

Mr. EVERETT. Good morning.

Mr. DEAL. Mr. Evans, fellow veterans, guests, I have with me this morning Dr. Carter Mecher who is the Clinical Manager for the Atlanta network; and Mr. Jimmie Clay, who is the Director of the Central Alabama Veterans Health Care System.

I appreciate this opportunity to update you on the integration of the Montgomery and Tuskegee VA Medical Centers. I would like to discuss three points involving this integration.

Number one, the integration of these facilities will improve quality, access, and cost effectiveness of health care for our veterans.

Number two, I believe the integration will improve the long-term viability of both Montgomery and Tuskegee Medical Centers.

Number three, I believe the integration efforts at Central Alabama are in keeping with Dr. Kizer's "Vision for Change" and "Prescription for Change."

I believe the integration will highlight the clinical strengths of each facility and improve the quality of care at both in the process. For example, Montgomery's greatest strength is the delivery of acute inpatient services, and Tuskegee's strength is the delivery of intermediate and long-term care services. Currently both facilities are experiencing a significant decline in acute inpatient services,

with Montgomery experiencing an acute medicine average daily census of less than 50 patients. In fact today as we speak it is less than 40.

By moving acute inpatient services from Tuskegee to Montgomery our veteran patients will receive the benefit of a state-of-the-art acute care facility in Montgomery and improved quality of care as a result of better distribution of staff. Similarly, by consolidating all intermediate and long-term care at Tuskegee our veterans will benefit from modern facilities, better staffing, and expertise in intermediate and long-term care, as well as a new 120-bed nursing home to be activated later this fall.

The surgical services currently being offered would also be greatly improved by the integration. A report from the VA's Inspector General suggested that the quality of surgery at Montgomery could be greatly improved by consolidation to increase the surgical workload. The increased surgical workload will allow the surgical teams to maintain their skills by experiencing a greater variety and volume of cases. The result will be improved quality, and eventually, I believe, increased cost effectiveness.

Improved primary care access at both facilities will be funded from the savings which I believe will emanate from integrating these two facilities.

The medical inspector's report was critical of what they perceived an inordinately high ratio of administrative staff to clinical staff at Montgomery. We believe that the integration will help eliminate unnecessary administrative and leadership positions at both facilities, thereby freeing up more dollars for direct patient care for veterans. These dollars can be used to fund improved primary care access by opening community-based clinics such as the one scheduled to be opened in Dothan later this fall.

Mr. Chairman, I might add parenthetically here that regardless of the progress of this integration we are prepared to go ahead and open the Dothan community-based clinic. We have budgeted for that, and while we are relying on it for recurring savings, we do have enough venture capital to open the clinic and run it for the first year of operation.

There has been some concern expressed by some of the stakeholders at both Montgomery and Tuskegee that the integration will result in the eventual takeover of one facility by the other, resulting in the closure of the other. In fact I believe that the integration of these two facilities will help improve the long-term viability of both. The integration will help to improve Montgomery's inpatient acute care census and the quality and viability of its surgical program. The integration will also strengthen Tuskegee's intermediate and long-term care programs. The result, I believe, is increased quality and utilization of both facilities at much-improved cost effectiveness.

The integration of Montgomery and Tuskegee is in keeping with Dr. Kizer's "Vision for Change" and "Prescription for Change." These documents articulate the need for the VA to radically transform the nature of the organizational structure, the health care delivery system, and perhaps most importantly the corporate culture of VHA.

If the VA is to remain viable into the Twenty-First Century we clearly must take bold efforts to improve the quality of care, customer service, access, and cost effectiveness of our services. These changes must make—that we must make will be difficult. Changes that will occur in Montgomery and Tuskegee and indeed throughout the VA will produce understandable anxiety and no doubt some resistance from key stakeholders, especially our veteran patients and employees.

There are some who do not want any changes in the way veterans' health care has been historically provided. However, in my opinion, that expectation is unrealistic given veteran demographic trends, physical realities, advances in medical technology, and changes occurring throughout the Nation in health care delivery.

When we began the initial planning for this integration a little over a year ago, at that time there was very little experience in the VA for conducting these integrations. And, Mr. Chairman, as you indicated, these are very difficult and challenging things to do. Indeed, I am not aware that there is even a template available for such mergers in the private sector, and the reason is because of that complexity. There is a unique mix of clinical programs, demographic, geographic, social, economic, and cultural issues. Our planning efforts, while clearly not perfect, were an attempt to involve employees and other stakeholders from both facilities in a grassroots process to design the organizational structure of the integrated facility. It was hoped that this process would not only lead to better design, but to improved communication and buy-in.

A large number of employees and other stakeholders in both facilities devoted hundreds of hours, producing outstanding planning documents to guide us through this integration effort. Those employees developed a plan designed to maintain a fair balance of jobs being shifted between the facilities, and I want to publicly thank them for their hard work and their dedication to America's veterans.

Mr. Chairman, I would also like to thank you for your interest in American veterans. Through the collective efforts of your subcommittee staff, the General Accounting Office, and the VA staff, I believe we have made great strides towards enhanced communication and shareholder involvement. And I believe those efforts on your part have led to a much-improved planning process that will ultimately, I hope, come to fruition and mean a better organizational design. I want you to know that I accept personal responsibility for any shortcomings in the integration planning process or in a failure to adequately communicate with our stakeholders. In summary, I believe in the long term that this integration will be in the best interest of veterans, employees, and the American taxpayers.

Mr. Chairman, thank you for the opportunity to discuss this matter, and for your interest in America's veterans. And Dr. Mecher, Mr. Clay, and myself stand ready to answer any questions you may have.

[The prepared statement of Mr. Deal appears on p. 41.]

Mr. EVERETT. Thank you very much, Mr. Deal. Any other members of your panel who want to testify?

Mr. DEAL. Not for an opening statement, sir.

Mr. EVERETT. Let me start off by saying if the integrated planning is carried out what services will each medical center be responsible for?

Mr. DEAL. I will start out on that one and then these——

Mr. EVERETT. The way you see it now.

Mr. DEAL (continuing). Have these gentleman elaborate.

The inpatient acute medicine will all be done in Montgomery as envisioned by the integration plan. Inpatient surgery will all be done at Montgomery as envisioned by the integration plan. Intermediate and long-term care will all be done at Tuskegee. And both facilities will have enhanced primary care, as indeed we are enhancing primary care throughout the network and throughout the VA system, as you know. Most of the tertiary care will continue as it is to be referred by either facility to Birmingham in most cases; in some instances Atlanta VA Medical Center.

Mr. EVERETT. You mentioned intermediate care. Seems to be a step-down from acute care. And I would normally think of it being located in the same location as acute care. Yet it is being separated from acute care of to Montgomery. Now, first of all I guess we need to get a good definition of what we are talking about when you say immediate care. Which patients are we talking about?

Mr. DEAL. I am going to defer to Dr. Mecher, if he would.

Dr. MECHER. The patients in intermediate care are actually fairly similar to the patients who are in extended care or in the nursing home. They tend to be patients who are difficult to discharge back to home, who have been in the hospital on acute care services and now, because of their other concomitant conditions, will require longer lengths of stay in an extended care facility for some period of time. And so those patients are more closely aligned actually with extended care and nursing home services than acute care.

Mr. EVERETT. How long, on the average, do these intermediate care patients stay in the facility?

Mr. MECHER. I do not have the exact data in front of me, but I would guess these patients——

Mr. EVERETT. Two weeks, a month, 3 weeks?

Mr. MECHER. A month approximately.

Mr. EVERETT. But the need for acute care is no longer present?

Mr. MECHER. Yeah, that is right, the need for acute care is no longer present. And now they are either trying to stabilize the patient to put the patient into a lower level of care, which would maybe be at home, or potentially into a nursing home. So a large number of those patients actually transition from intermediate medicine into a nursing home care bed either in the VA or potentially in the community.

Mr. EVERETT. Is this modeled after other facilities where you have long-term care that you also have immediate—intermediate term care?

Mr. MECHER. Yes.

Mr. EVERETT. I am going to try to move this a little closer and talk a little louder.

How much money would the integration save, and can VA provide support for this—its estimated cost benefit analysis?

Mr. DEAL. Mr. Chairman, the question of how much it can save and what the cost benefits analysis ultimately produce I think is

a moving target. At a minimum the integration plan articulates a savings of 49 full-time equivalent positions. In salary dollars at our average salary, that equates to roughly $2 million recurring every year at a minimum that—that would be saved as a result of the integration.

Now, there clearly are going to be some up-front costs, some investments in some equipment, some construction issues which will have to be done to accommodate the integration of the various aspects we have talked about this morning. But those will only be one-time up-front costs, and the recurring costs will continue to grow.

The experience that the VA has seen in other integrations across the country is that there are considerable savings that begin to be generated as one gets experience as an integrated facility because of economies of scale that develop, because of eliminating the duplication of effort that exists at the two facilities. But we think, just as I said very conservatively, a minimum of $2 million. And I expect in the out years that number will probably be considerably more.

And we intend to use those resources for a couple of things. One is to try to improve access by opening community-based clinics such as the one in Dothan and others that we are planning in Alabama. But also, quite honestly, just to take care of the aging veterans who are demanding more and more services in our system at a time when I think any of us could reasonably expect, in best-case scenario, probably straight-line budget into the future for VHA.

Mr. EVERETT. How many jobs can be eliminated at each facility, and how many jobs at each facility are vacant, and how many have a person currently on—occupying the slot?

Mr. DEAL. I do not have the numbers in front of me of the number at each facility. The integration plan articulated 49 positions that would be eliminated just solely due to the integration itself.

Mr. EVERETT. Are we talking about slots or actually people?

Mr. DEAL. We are talking about slots, essentially.

Mr. EVERETT. In other words, there is not necessarily a name connected with that slot?

Mr. DEAL. That is true, sir. And in fact if you look at what we call the on-board strength or the actual number of employees at both facilities at the end of June of 1996 and compare that with where they are at the end of June of 1997 there is a considerable reduction of over 120 FTE from last year to this year. That is by and large unrelated to the integration efforts. It is mostly related to the general downsizing of the VA system that is occurring all across the agency as you know.

Mr. EVERETT. Would you provide that information I just requested for the record?

Mr. DEAL. Yes, sir, I will.

(Subsequently, the Department of Veterans Affairs provided the following information:)

DEPARTMENT OF VETERANS AFFAIRS
CENTRAL ALABAMA VETERANS HEALTH CARE SYSTEM
(CAVHCS)

EMPLOYEE FTEE BY PAY PERIOD

PAY PERIOD 96-11

SERVICE	EAST CAMPUS	WEST CAMPUS	TOTAL
Director's Office	11.0	5.0	16.0
Acquisition & Materiel Mgmt.	22.0	26.0	48.0
CHEP/TAHEC	3.0	N/A	3.0
Decision Support	00.0	00.0	00.0
Environmental Mgmt. Service	110.0	33.0	143.0
Nutrition and Food Service	105.5	25.5	131.0
Engineering Service	104.0	38.0	142.0
Fiscal Service	16.0	22.5	38.5
Information Resource Mgmt.	12.0	13.5	25.5
Health Administration/MAS	44.0	43.6	87.6
Library Service	5.0	2.0	7.0
Medical Media Service	5.0	N/A	5.0
Police and Security	16.0	8.0	24.0
Human Resources Mgmt.	12.0	8.0	20.0
Voluntary Service	4.0	2.0	6.0
Prosthetics	1.0	7.7	8.7
Chief of Staff	7.0	4.0	11.0
Quality Mgmt.	12.0	7.0	19.0
Extended Care	7.0	N/A	7.0
Ambulatory Care/Primary Care	15.0	N/A	15.0
Chaplain Service	3.0	1.5	4.5
Dental Service	14.0	9.0	23.0
Pathology & Lab. Medicine	27.0	20.0	47.0
Medical	19.0	17.9	36.9
Pharmacy Service	30.0	28.5	58.5
Psychiatry Service	18.5	N/A	18.5
Psychology Service	28.0	N/A	28.0
Nursing Service	513.0	152.0	665.0
Radiology/Imaging Service	17.0	13.0	30.0
Recreation Service	12.0	N/A	12.0
Physical Medicine & Rehab.	30.0	4.5	34.5
Audiology-Speech Pathology	5.0	N/A	5.0
Surgical Service	16.0	6.5	22.5
Social Work Service	31.0	6.0	37.0
Domicilary	11.0	N/A	11.0
TOTAL	**1286.0**	**504.70**	**1790.7**

*Does not reflect end of pay period numbers
*Excludes Canteen Service and MCCR

DEPARTMENT OF VETERANS AFFAIRS
CENTRAL ALABAMA VETERANS HEALTH CARE SYSTEM
(CAVHCS)

EMPLOYEE FTEE BY PAY PERIOD

PAY PERIOD 97-01

SERVICE	EAST CAMPUS	WEST CAMPUS	TOTAL
Director's Office	12.0	3.0	15.0
Acquisition & Materiel Mgmt.	22.0	23.0	45.0
CHEP/TAHEC	4.0	N/A	4.0
Decision Support	2.0	3.0	5.0
Environmental Mgmt. Service	91.0	33.0	124.0
Nutrition and Food Service	89.0	24.5	113.5
Engineering Service	96.0	39.0	135.0
Fiscal Service	13.0	18.25	31.25
Information Resource Mgmt.	11.0	13.0	24.0
Health Administration/MAS	36.0	39.6	75.6
Library Service	2.0	1.0	3.0
Medical Media Service	5.0	N/A	5.0
Police and Security	15.0	8.0	23.0
Human Resources Mgmt.	8.0	8.0	16.0
Voluntary Service	3.0	2.0	5.0
Prosthetics	1.0	7.8	8.8
Chief of Staff	8.0	6.0	14.0
Quality Mgmt.	9.0	7.0	16.0
Extended Care	6.0	N/A	6.0
Ambulatory Care/Primary Care	31.0	12.17	43.17
Chaplain Service	3.0	2.0	5.0
Dental Service	11.0	9.0	20.0
Pathology & Lab. Medicine	24.0	20.0	44.0
Medical Service	17.0	10.0	27.0
Pharmacy Service	31.0	26.74	57.74
Psychiatry Service	17.0	N/A	17.0
Psychology Service	24.0	N/A	24.0
Nursing Service	500.0	141.00	641.0
Radiology/Imaging Service	16.0	14.0	30.0
Recreation Service	10.0	N/A	10.0
Physical Medicine & Rehab.	26.0	4.5	30.5
Audiology & Speech Pathology	4.0	N/A	4.0
Surgical Service	15.0	6.5	21.5
Social Work Service	26.0	8.0	34.0
Domicilary	16.0	N/A	16.0
TOTAL	**1204.0**	**490.06**	**1694.06**

*Does not reflect end of pay period numbers
*Excludes Canteen Service and MCCR

DEPARTMENT OF VETERANS AFFAIRS
CENTRAL ALABAMA VETERANS HEALTH CARE SYSTEM
(CAVHCS)

EMPLOYEE FTEE BY PAY PERIOD

PAY PERIOD 97-11

SERVICE	EAST CAMPUS	WEST CAMPUS	TOTAL
Director's Office	12.0	5.0	17.0
Acquisition & Materiel Mgmt.	22.0	24.0	46.0
CHEP/TAHEC	3.0	N/A	3.0
Decision Support	2.0	3.0	5.0
Environmental Mgmt. Service	93.0	34.0	127.0
Nutrition and Food Service	99.0	21.5	120.5
Engineering Service	95.0	38.0	133.0
Fiscal Service	13.0	19.0	32.0
Information Resource Mgmt.	8.0	11.0	19.0
Health Administration/MAS	38.0	22.0	60.0
Library Service	3.0	1.0	4.0
Medical Media Service	5.0	N/A	5.0
Police and Security	15.0	10.0	25.0
Human Resources Mgmt.	9.0	7.0	16.0
Voluntary Service	4.0	2.0	6.0
Prosthetics	2.0	7.0	9.0
Chief of Staff	7.0	5.0	12.0
Quality Mgmt.	7.0	6.0	13.0
Extended Care	7.0	N/A	7.0
Ambulatory Care/Primary Care	58.0	55.23	113.23
Chaplain Service	3.0	2.0	5.0
Dental Service	11.0	9.0	20.0
Pathology & Lab. Medicine	25.0	19.0	44.0
Medical Service	17.0	10.16	27.16
Pharmacy Service	30.0	25.4	55.4
Psychiatry Service	16.0	N/A	16.0
Psychology Service	22.0	N/A	22.0
Nursing Service	424.0	120.6	544.6
Radiology/Imaging Service	17.0	13.0	30.0
Recreation Service	10.0	N/A	10.0
Physical Medicine & Rehab.	24.0	4.5	28.5
Audiology & Speech Pathology	4.0	N/A	4.0
Surgical Service	12.0	6.5	18.5
Social Work Service	27.0	8.0	35.0
Domicilary	18.0	N/A	18.0
TOTAL	**1162**	**488.89**	**1650.89**

*Does not reflect end of pay period numbers
*Excludes Canteen Service and MCCR

Mr. EVERETT. I appreciate your comments about the Dothan clinic. Would you briefly describe to me what the current delay time is, current delay occurs?

Mr. DEAL. There was initial invitation for bids put in what is called the "Commerce Business Daily" which is a newspaper that potential bidders for government work subscribe to. And there are statutory requirements for the number of days that that must remain in the "Commerce Business Daily." That was done sometime in the April-May time frame. I have forgotten the exact date. I could make that available to you later.

What subsequently occurred, there was a pre-bid conference for potential interested vendors or bidders in the contract. What subsequently occurred is we only ended up with one responsive bidder who put in a bid. After the bids were opened and that became known, there was a potential bidder who apparently indicated that they had not bid because they wanted some demographic information about the veterans that would be in the catchment area of the Dothan clinic, and we asked our regional counsel and general counsel's office to get involved, to give us a legal interpretation on that and to see whether or not we were on firm ground with respect to the contracting law. They decided the best thing for us to do would be to go back out, reannounce, and give whatever demographic information any potential vendor wanted.

We have done that. It is process. The request for bids has been redone. It is being reviewed now by our legal staff. We expect it to go in the "Commerce Business Daily" by sometime around the middle of August. And we would expect that if it runs a predictable course this go-around we are looking at late fall, sometime around early to mid-December for actual activation of the Dothan CVOC.

Mr. EVERETT. I know the veterans down in Dothan area who have had to travel a great distance will be pleased to hear that you feel like you are moving forward, making progress.

In your testimony you alluded to medical inspector's visit to Montgomery. When was that—when did it occur, and did the medical inspector make recommendations, and what are the status of those recommendations?

Mr. DEAL. That visit was conducted roughly 2 years ago. Again, I can provide that for the record. I am not sure that I have it in front of me right now. The initial reason for the medical inspector being called in had to do with allegations of substandard care in surgical service. And when the medical inspector's office came on site they expanded the scope of that investigation to look at both some concerns about leadership and overall quality of care issues that resulted from that visit.

They made a myriad of recommendations. Actually there was something like three different documents. There was a preliminary report, and then what was called a final draft, and then the final final, that was actually authored in October of 1996.

But the crux of the recommendations, I would say, focused on concerns about surgical service, and most of the concerns there had to do with low volume, the fact that the quality of surgery could be improved significantly by increasing the number of procedures that were performed.

And they also had some similar concerns about other clinical ramifications of just low volume, the low ADC the occupancy rate that was at the Montgomery hospital, and also expressed some concerns about leadership and the environment that they felt at least existed in the medical center as a result of that leadership.

Mr. EVERETT. This is a question I should not have to ask, but apparently those who have had the answer was not—have not chosen to make public. Is there any VA plan to—or intent to close either Montgomery or Tuskegee?

Mr. DEAL. Unequivocally no, there is not.

Mr. EVERETT. Thank you.

I have a question or two, but right now I would like to—for later. But right now I would like to turn to my ranking member and friend, Lane Evans.

Mr. EVANS. Thank you, Mr. Chairman.

Mr. Deal, what are the lessons that you have learned so far going through this process that might help us in Illinois understand a little bit more about what should be done?

Mr. DEAL. I think two things, Mr. Evans, come to mind: communicate, communicate, communicate, communicate. You cannot do enough of it, you can't do too much of it. And in retrospect, although we had over 300 separate instances either face-to-face or written communications that went out to a variety of our stakeholders, it was not enough; and in some cases it was not frequently enough.

The second lesson I learned is related to communication, and that is that in our discussions with the General Accounting Office and with the chairman's staff it has become clear to me that the planning process that we had could have been improved by bringing in some of the key leaders earlier on in the entire planning and implementation process. By that I mean naming a director of the integrated facility, hiring the service chiefs of the integrated facility very early on so that those individuals could be involved in some of the grassroots planning efforts that need to go on to ultimately plan the integration.

And I would also say, related to that, that the planning process should have been more comprehensive. We tended to choose an incremental approach and I think there would have been some value in all of the services developing their plans pretty much simultaneously so that one could get a feel for what the total impact was going to be on the organization.

I would put a caveat there, though; and that is that seems to me there is a fine line between the appropriate amount of planning and what I will call paralysis by analysis. I mean, if it is the right thing to do, and this one to me seemed like a bit of a no-brainer with two hospitals that were 35 miles apart, and basically two sets of administrative overhead for those hospitals that we knew could immediately save $2 million which we could badly use to reinvest. So I felt some need to move fairly quickly. But on the other hand I think a little more patience, in retrospect, would have paid dividends in the long term.

Mr. EVANS. To what extent have you followed the direct guidance of facility integrations that Dr. Kizer is currently developing, and

could you tell us what your approach has been and how your approach compares to that outlined by Dr. Kizer.

Mr. DEAL. We have seen both the five-step process that Dr. Kizer has developed and also a publication that was put out on lessons learned from integrations. In fact we have seen a couple of iterations of that. I have also tried to read a lot about this in professional journals because it is going on, as you know, with some degree of regularity in the private sector as well. And I think some of the lessons are repeated over and over.

I mean, it is first of all a very difficult and very complex thing to do. It is clear that stakeholder involvement in the process is important, clear that stakeholder buy-in is important. And I think the way you get that is with both improved communication and improved planning. I think as much specific information as can be generated from the process, ultimately both the planning itself and the stakeholders are better off for it.

Mr. EVANS. Now, the new clinic that you are going to be opening in Dothan—is that the name of the——

Mr. DEAL. Yes, sir.

Mr. EVANS. We have a lot of stakeholders here today that I think should be informed as to what that offers to veterans. In my own case having a veterans' outpatient clinic established in a very rural part of my District means that they do not have to go from Quincy, IL, to Iowa City, IA—about a 3 hour drive—to get to any medical exams, vaccinations and prescriptions and so forth. Can you tell us how this will not only help veterans there, but also how it might lessen the impact of some of the cuts that you may be facing in places like this by putting more emphasis on outpatient care?

Mr. DEAL. Yes, sir, I will be glad to.

First of all the clinic in Dothan is projected to enroll about 2,500 unique veterans. They will be mostly veterans from southern Alabama, perhaps some from the very northern counties in the Florida panhandle. The whole idea of these community-based clinics is to emphasize primary care out in the community, to move the VA access closer to where veterans live.

We found out that a number of good things result from that. The number one reason that veterans using the VA who turn 65 years old leave the VA when they have become entitled to Medicare benefits, is lack of access. Typically, they have to drive too far, as you articulated in the Iowa City and Quincy case, to reach a VA facility. And we think by putting them more out into the community it will improve the access, hopefully make us more user friendly.

Although we have also demonstrated that another byproduct, a positive byproduct of that is that as much as we can move care out of the hospital and as much as we can emphasize primary care, it is actually a benefit to the patient. You do not want to be in a hospital unless you are very sick, because there are sick people in hospitals. And there is a lot of literature in the public and private sector both, that indicates the sooner you can get a person discharged to the lowest level of care the better off that person is.

And it is also more cost effective. So we believe, in an era of straight-line budgets, that we can reach out to more veterans with the same amount of resources than we would otherwise be able to take care of.

Mr. EVANS. Well, we just had our 10,000th visit, and that means 10,000 trips that did not have to be taken to Iowa City in order to receive benefits. Hope you have the same kind of success.

Mr. DEAL. Thank you, sir.

Mr. EVANS. Thank you, Mr. Chairman.

Mr. EVERETT. Thank you.

I have got a couple more questions here. Let me ask you, is there a comprehensive space utilization plan for each facility which is part of the overall proposed integration plan?

Mr. DEAL. I am sorry, sir, I did not hear the first part of your question.

Mr. EVERETT. Let me get this a little closer.

Is there a comprehensive space utilization plan for each facility which is a part of the overall proposed integration plan? I do not seem to be able to get a clear picture of whether you have got an overall space utilization plan that fits together with integration.

Mr. DEAL. It was not entirely clear to me, either, to be truthful with you, until we spent a couple days meeting with the GAO in our offices in Atlanta, just exactly what level of detail they were interested in and I think you and your staff were interested in.

We have a space utilization plan. I do not think it is yet of sufficient detail to answer many of the questions that you and others of our stakeholders would like to have addressed and indeed that we need to address in the process. I think as we go forward with the integration process, if we are allowed to do that, that procedurally one of the next things I would see happening is getting the key leaders on board to begin fleshing out some of the intricate details of how each service is going to look, both in terms of staffing and in terms of space and what space would be occupied in what areas.

Perhaps the most obvious example of that, or one that has been prominently discussed, anyway, is the whole issue of food and nutrition and whether or not it would get consolidated at one facility or the other, or whether you would have a food and nutrition service at both facilities.

And I think from my perspective the experts ought to best decide that issue. And I think it would serve us all better to get an expert on board who did not particularly have a bias from either facility's perspective and wanted to just do the right thing from the standpoint of delivery of that service to that——

Mr. EVERETT. In regard to getting experts on board, you are going to have a chief of staff change I think before too long.

Mr. DEAL. Yes, sir.

Mr. EVERETT. Would you fill these top slots prior to making all the decisions on, for instance, just what you said; let the experts—let the people that are going to be responsible for it help make those decisions?

Mr. DEAL. Yes, sir, we could. And I personally think that would be prudent. The time line, if you will, the advance lead time needed to do that is substantial, though, because of the statutory processes that the Office of Personnel Management has for announcing federal jobs, and especially if somebody is selected from outside the Montgomery or Tuskegee facility to lead one of those services. Frequently they have another job to leave and movement to get them

here and so forth; is typically a sixty to ninety day process from beginning to end.

Mr. EVERETT. And in reference to this, well, let me just very frankly say we have not seen any—a great deal of evidence so far that the VA evaluated alternate integration scenarios and used a best-approach selecting process. That is something I hope very much that we will take another look at to see what the action and reaction is and how—if we do this, how it is going to affect something else and what space that will be perhaps created that will maybe affect a decision that we made earlier on. So I hope very much that we can have some further conversation about that.

Mr. DEAL. All right, sir.

And at this time I appreciate your appearing here today and we will call up the next panel.

Mr. EVANS. Mr. Chairman, may I——

Mr. EVERETT. Oh, I am sorry.

Mr. EVANS. Mr. Clay, before you leave I just want to ask you one question. Could you comment on your views of the process for, you know, the change at Tuskegee and Montgomery Medical Centers. Do you believe it is the best process for this integration, and what about other integrations?

Mr. CLAY. I did not hear your entire question, sir. Could you repeat your question.

Mr. EVANS. Yes, sir.

Can you comment on your view of the process, sir, for the change at Tuskegee and Montgomery Medical Centers.

Mr. CLAY. Has it brought about any changes?

Mr. EVANS. I am sorry?

Mr. CLAY. You say had it brought about many changes at both Tuskegee and Montgomery?

Mr. EVANS. Yes.

Mr. CLAY. Well, at this point it has brought about some because of the fact that we were in the planning process and I think it is more of an anticipation than anything else. Since we have progressed to the third phase which we have not gone into, some changes have come about.

For an example, the intermediate medicine, we have effected that consolidation where we have moved the 10 patients, over a 2-week period, from the west campus of Montgomery to the east campus in Tuskegee. That was one change.

And there were some other changes, but not of any major magnitude. But I think the major concern would be the staff wanting to know where they will be assigned.

Mr. EVANS. All right. Thank you, Mr. Chairman.

Mr. EVERETT. Thank you. I would like to thank the panel.

At this time we will call up the next panel: Mr. Stephen Backhus, GAO; and Paul Reynolds with the GAO.

Gentlemen, welcome. It is good to see you again. We will proceed with your testimony.

STATEMENT OF STEPHEN BACKHUS, DIRECTOR, VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, GENERAL ACCOUNTING OFFICE accompanied by PAUL REYNOLDS, ASSISTANT DIRECTOR, VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, GENERAL ACCOUNTING OFFICE

Mr. BACKHUS. Thank you, Mr. Chairman. It is good to be back here in Montgomery. Thank you for having us.

Before I begin I would like to introduce a couple of other people here with us.

Mr. EVERETT. Please do.

Mr. BACKHUS. Okay. Sitting back here is Mr. Byron Galloway and Mr. Terry Saiki from our office in Washington, DC and Seattle offices respectfully who have helped us evaluate integrations around the country. They put in a lot of hard work.

Mr. EVERETT. Welcome, gentleman.

Mr. BACKHUS. Mr. Chairman and Mr. Evans, we are pleased to be here today to discuss our ongoing evaluation of VA's medical facility integration in Tuskegee and Montgomery. Our observations are based on a visit to the two facilities here on May 5th, our review of planning documents, and subsequent discussions with VA headquarters, VISN, and facility officials. We have also, as you know, been examining other VA facility integrations around the country as well as discussing integration issues with private health care providers and consulting firms.

On the basis of our work to date it appears that a lot of good planning for this integration has occurred, but it is not complete in areas such as making key decisions on whether and how to restructure certain services like nutrition and food; fully assessing the probable impact of clinical, administrative, and patient support service changes on veterans and employees; and determining how savings will be reinvested to benefit veterans.

Moreover, some stakeholders have found it difficult, if not impossible, to assess the reasonableness of VA's decisions and to ultimately buy into them without the benefit of information from completed planning activities facility-wide. Because integrating facilities involves inherently difficult issues and may have some adverse impact on some stakeholders, it seems imperative that VA complete its planning before proceeding any further with implementation.

Before elaborating I would like to take a moment to describe the importance of and potential benefits of this and other integrations to veterans and the taxpayers. Facility integrations are part of VA's nationwide strategy to restructure its health care delivery systems similar to the private sector, and to improve access, quality, and the efficiency of care provided to veterans. VA estimates that integrations nationwide have already generated over $83 million in savings. Veterans benefit from these savings when they are used to open new clinics, offer new services at existing medical facilities, and shorten waiting times. VA expects Montgomery and Tuskegee—the integration to save several million dollars annually, and also expects to reinvest part of these savings to establish or expand primary care clinics. Now I would like to discuss in more detail our assessment of the Tuskegee/Montgomery integration planning efforts.

VA's integration planning approach has many positive features. For example, the facilities are using work groups composed of both facilities' employees. Involving local employees in the planning activities appears beneficial in that it expedites the process; includes those most familiar with the operations of each facility; it permits their involvement with the VA has been?

But our work to date also raises concerns about the process. First, integration decisions are generally made incrementally; that is, on a service by service basis at varying times throughout the process. Also planning and implementation activities frequently occur simultaneously without a detailed comprehensive plan. For example, the cornerstone of the Montgomery/Tuskegee integration is the consolidation of acute care at Montgomery and long-term rehabilitative and psychiatric care at Tuskegee.

In addition, administrative services are to be centralized at Tuskegee. These decisions, however, were made without adequately exploring other options or taking into account how future changes in workload might affect the facilities.

Also because VA had not yet made decisions on how to integrate a number of other services, key questions about the availability of space in Montgomery remain unanswered. VA is still considering, for instance, several options for restructuring the nutrition and food service which could make more space available at Montgomery for other services.

I might also mention that several significant service chief positions are vacant. Our analysis of other VA integrations indicates that these people are key to comprehensive planning and need to be brought on board early in the planning process. Private health care providers and consulting firms with whom we spoke appear to approach integration with a more structured process that places greater emphasis on reaching implementation decisions after comprehensive integration planning is completed.

The second concern we have about the process involves stakeholder participation and buy-in. We believe both could be enhanced if VA provided them detailed information on all aspects of the integration before beginning implementation. For example, while Montgomery and Tuskegee facilities have worked hard to involve stakeholders, some decisions have been difficult for them to accept without having been told specifics about how services will be integrated, how potential changes will affect veterans and employees, why selected alternatives are the best available, how much potential changes will cost to implement and save overall, how we—and how VA will reinvest savings to benefit veterans. I also know that VA's differing and conflicting responses to questions about potential construction and renovation costs needed for the two facilities has cast considerable doubt among stakeholders and us about the sufficiency of planning.

Certainly these examples point to the need for more comprehensive planning and effective communication with stakeholders. VA is currently considering ways to improve its integration planning, such as developing a more structured process that should increase the availability of information on important decision points, and toward this end we encourage VA to follow through with these im-

provements because the greatest benefits to veterans and the taxpayers are yet to be realized.

This concludes my prepared statement. I will be glad to answer questions—and Paul will help me here—that either of you may have.

[The prepared statement of Mr. Backhus appears on p. 48.]

Mr. EVERETT. Thank you very much.

Let me start off by saying: In your opinion was there an adequate plan in place to begin implementation of the integration? And how does GAO view the situation with respect to the going forward with the integration?

Mr. BACKHUS. Well, I think I probably have two or three comments in this regard. First, while there has been much good planning that has occurred, in our view it is incomplete. And I believe until certain plans are finalized and provided in more detail, then perhaps the integration should not proceed.

However, in order to complete some of that planning people need to be brought on board in key positions to do the planning; for example, the service chiefs. From what we have learned in looking at integrations around the country, and as Mr. Deal indicated, there is a need to have the key people on board early on to do the planning, and VA needs the authority to do that.

And secondly, as you mentioned in your opening statement, when it comes to the acute care, they need to be able to complete the movement of people in order to maintain the quality of care. So I think they probably need to proceed and complete that element of it.

But the planning for rest of the components, in my view, needs to be completed, and stakeholders informed before implementation proceeds.

Mr. EVERETT. I notice on page 3 of your written complete testimony you say that other health care—private health care providers and public firms have a more structured method for integration.

Mr. BACKHUS. That is true. But it is also true that no two integrations are alike. However, the process used, in our view, is essentially something very similar to what Dr. Kizer is proposing in his five-step process. There are key decision points along the way where people need to be informed—and at least accept the facts of the plans before changes proceed. That means, in our view, more detailed planning is needed based on what we have seen here and certainly what we have seen in Chicago and other places around the country. Those key questions have to be answered before things are implemented.

How are things going to be integrated? How are services going to be integrated? What alternatives were considered? Why are those alternatives the best? What is the impact on veterans, employees, and other stakeholders? How is the money that is going to be saved reinvested to the benefit of veterans? Until those questions are answered I do not believe that we ought to be going forward in implementing change.

Mr. EVERETT. Well, part of VA's overall strategy for veterans' health care in the next few years is increased forms of access for veterans to the VA health care system by moving from hospital-based acute care to ambulatory clinic-based primary care. Now,

this reduces cost by improving efficiency, and at the same time it does—if done correctly, will improve the quality of care for veterans. The money saved can then be reinvested to improve access to care for veterans by increasing the number of points of access.

I understand that the VA's regional network would serve Central Alabama as a—they plan to do that. Has GAO reviewed that plan, and what does it show for planning points of Central Alabama and for the whole State, and what other States are in the regional network, and does it show them also?

Mr. BACKHUS. We have looked at the plan. The other States in the region are South Carolina and Georgia. As I recall, there is a mention of one additional clinic to be built or established in Alabama—Dothan—and seven each in South Carolina and Georgia.

The criteria, as I recall, is that these clinics would be established where there are at least 1,200 veterans to provide a base large enough to justify a primary care provider, and in locations where currently veterans are at least an hour or more away from an existing VA facility.

Mr. EVERETT. Is the adequacy of stakeholder involvement something you look at? And if so, what is your evaluation of Central Alabama?

Mr. BACKHUS. We did. In fact we focused quite a bit on that. And I would say the answer is mixed.

It is true that both facilities, Tuskegee and Montgomery, worked hard at trying to be inclusive in various ways. For example, employees are involved greatly in the working group process. And that, I think, is a very positive thing.

But I will tell you that in many respects the stakeholders are frustrated by receiving conflicting information from time to time, and they really do not understand in some cases the large picture of what is being done, and most certainly they do not understand the specifics about what is occurring here and the impact on them.

So obviously there is a need here to make a better effort and engage more frequently, perhaps, and certainly at the key points along the way, stakeholders from all aspects.

Mr. EVERETT. And have there been other VA facility integrations that have had serious problems?

Mr. BACKHUS. I would say, based on our examination thus far, which includes a detailed analysis in Chicago and one occurring here in Alabama, as well as some 16 other integrations nationwide, that they have all had difficult moments. These things are not easy. And probably the most common difficulty they have had is with stakeholders, in terms of getting people to understand what it is they are trying to accomplish and providing them enough detail for them to feel comfortable and confident. So that is a common theme that seems to run through the other integrations as well.

Mr. EVERETT. In his testimony in Washington last Thursday Dr. Kizer, VA's Undersecretary of Health, as you alluded to, described the five-phase planning process. One of the phases involved consideration of alternate integration scenarios. What is the reason for that, and what alternatives were considered at Central Alabama other than the plan actually proposed?

Mr. BACKHUS. Well, clearly the benefit and the purpose of exploring alternatives is to maximize the benefits and minimize the ad-

verse impact on stakeholders to make sure that the costs and benefits point to and bring us to the right conclusion.

In the case of the Central Alabama Veterans Health Care System we focused thus far on the administrative aspects of the integration. And it is our view that, up to this point, there has not been alternatives considered in that regard.

As I recall, the decision was made early on to centralize the services in Tuskegee, and the working groups formed for that particular issue basically had the job of attempting to find space at Tuskegee. And the particular reason was, as given to us, that there was not enough space in Montgomery, and that it was fair to move most of the administrative functions to Tuskegee. I do not see an analysis that shows, based on longer term workload predictions and decisions about other services which have yet to be made, a good case to justify that particular decision.

Mr. EVERETT. Could that method lead to unnecessary construction costs?

Mr. BACKHUS. Quite possibly. This is another area where we have spent considerable time pursuing and trying to understand better. And frankly at this point I cannot tell you what the final construction plans and renovation costs are going to be, because I do not think that has been decided, either. But it seems to me that that is part of the equation. That kind of an analysis needs to be made and those alternatives considered before decisions are made as to where people are going to be located, because renovation and construction costs can be considerable.

Mr. EVERETT. At this time I will yield to my colleague, Mr. Evans, for some questions.

Mr. EVANS. Thank you, Mr. Chairman.

What has been and should be the role of the VA headquarters in Washington in the planning for the future of the Montgomery and Tuskegee facilities?

Mr. BACKHUS. Mr. Evans, I am sorry, I could not hear the——

Mr. EVANS. What should be—what has been and should be the role of the VA headquarters in Washington in the planning process for these two hospitals?

Mr. BACKHUS. Well, that is a matter of great debate in Washington. I am not so sure my view is going to comport with how VA sees their role in this. At the present time they are pretty much hands-off.

There is only one point in this process where the headquarters engages themselves, and that is at the proposal stage when they decide to proceed with planning or not.

At that point it is really up to the VISNs and the local facilities to do the balance of the planning. They are preparing some guidance, I am told, to try to help people work through the process with a "lessons learned" type of a manual, which is good.

Overall, it seems that this structure, as it is set up, is consistent with the movement toward the VISNs and decentralizing that authority. You know, health care requires local decisions and accountability, and that is why the process is established the way it is.

But there probably seems to be, in my view, a more engaging role that the headquarters ought to be providing because they have the benefit of learning how other integrations are going and the

pitfalls and troubles that have been encountered. I think that there is probably a need for more consistency in structure, and their role, as I see it, would be to provide more guidelines to people as to what really needs to be in a plan, at what key points people really need to involve the stakeholders in these key decision points, and be more specific telling people what they need to do.

Mr. REYNOLDS. If I may add a private sector view, the private sectors basically view these as regional decisions and so they let the regional people handle their mergers and consolidations. In VA's case it would be the networks who would be the regions, so from that standpoint, headquarter's position and the way they are doing this is somewhat aligning them with the way the private sector does it.

Mr. EVANS. All right. What has been the role of the academic institutions in this process here locally, the medical schools and——

Mr. BACKHUS. There are not any affiliations here with medical schools. But that is an interesting question as it applies to Chicago. And, Paul, why do you not take this question.

Mr. REYNOLDS. Well, there actually are a very limited medical school affiliation here, each with different partners, but it is only one or two residency slots, so it is very minor.

But the Chicago integration is really the first time the VA has tried to merge two highly affiliated medical centers. And in those cases there are well over a hundred—a hundred to a hundred and twenty residency positions, lots of faculty who come and practice at VA. There is a heavy research involvement at both the West Side and Lakeside facility in Chicago. So both the medical schools have a very big interest in the VA and the way VA delivers care. And in Chicago the facilities are 6 miles apart, where here they are I guess roughly 35 to 40 miles apart.

What VA has done in Chicago has allowed the medical schools to play a very heavy role in deciding how the integration should play out. They shared associate deans from each of the medical schools; one chairs the medicine work group in Chicago, one from the other institution chairs the surgery work group. So they have a very heavy involvement.

And I guess if we have one concern from having looked at that, it is that their self-interests may not always be the same as the veterans and you may get some competing of interests. And so human nature being what it is, it is difficult sometimes to make the best decisions when it is not in your own self-interest. So we have a concern, I guess, that possibly more independence may be needed in some places, such as Chicago.

Mr. EVANS. All right. Thank you, Mr. Chairman.

Mr. EVERETT. Thank you.

Another point was made in Washington testimony about health care management consulting that the private sector and both VA uses—that it is very important to have the service of a specific cost benefit analysis. What is your view of cost benefit analysis done as part of the integration planning here, and how much money does it appear to GAO that integration, as proposed, would save?

Mr. BACKHUS. Well, I have seen the same data that Mr. Deal mentioned earlier that elimination of management positions could achieve potential savings of about $2 million. However, that is the

extent of the analysis. And in my view what is really important here is that there be some further and more detailed presentation of all the other costs and benefits associated with this integration so that we have the complete picture as to what ultimately will represent the savings to this particular system.

I know that I—from my perspective—I have not seen that detail, so I cannot say that I am not confident stating to you that $2 million is the extent of savings. So, I do not know.

Mr. EVERETT. Can you determine, from VA's proposed plans, how many FTE reductions come from eliminating vacant positions, how many come from eliminating positions that are currently held by someone, and which of those facilities they affect?

Mr. BACKHUS. At this point I know that all of the savings have been attributable to vacant positions. It appears that that is going to be the case, at least up through maybe the next month or two. But I cannot tell you how many people are going to move where. I do not know that, nor how many people have to get retrained in jobs who may not have to move.

Also I cannot give you assurance that, from here on out, achieving the next savings of 50 people are going to be through vacant positions. They may very well begin now to dip into positions that are filled by people and that is part of what has occupied our time and attention here. We are trying to get those particulars—those specifics—so that we could be able to explain to others like you what the final picture was going to look like. However, I do not know that yet.

Mr. EVERETT. Finally let me ask you, from your view of this planning, do you get any indication at all that either the Montgomery facility or the Tuskegee facility will be closed?

Mr. BACKHUS. Nothing I have read, nothing I have heard or observed give me any reason to indicate that either facility will close. I have seen no evidence of that.

Mr. EVERETT. Oh, excuse me. Lane, do you have anything else?

Mr. EVANS. No.

Mr. EVERETT. Thank you very much.

Mr. BACKHUS. You are welcome.

Mr. EVERETT. We will have the next panel now, please.

The next panel is our VA panel, includes Mr. Gordon Shewmake, State Adjutant-Quarter Master, Veterans of Foreign Wars; Thurston Mosley, State Commander, Disabled Veterans of America; Mr. Will McKenzie, Vietnam Veterans of America; Mr. Andrew J. Cooper, American Legion; and accompanying him will be Mr. Jake Jacobson, Immediate Past State Coordinator, The American Legion.

Gentlemen, please have a seat, and welcome. As I said, Mr. Gordon Shewmake is the State Adjutant-Quarter Master of the Veterans of Foreign Wars. If you will, if you will begin your testimony and——

Did Gordon make it yet? All right, let us—if we will, we will just begin on your left down there and we will go forward.

STATEMENTS OF ANDREW J. COOPER, THE AMERICAN LEGION, ACCOMPANIED BY JAKE JACOBSON, IMMEDIATE PAST STATE COMMANDER, THE AMERICAN LEGION; THURSTON MOSLEY, STATE COMMANDER, DISABLED AMERICAN VETERANS; AND WILL McKENZIE, VIETNAM VETERANS OF AMERICA

STATEMENT OF ANDREW J. COOPER

Mr. COOPER. Mr. Chairman and distinguished members of the subcommittee, we welcome the occasion, as a stakeholder of the VA medical system, to offer a perspective on the organized Veterans Health Administration, FHA. The American Legion, Department of Alabama, appreciates the opportunity to communicate its viewpoints on the Department of Veterans Affairs, VA proposed merger/integration of VA medical facilities in Central Alabama. In concept the American Legion, Department of Alabama, supports the planned reorganization of Veterans' Health Care facilities. But has enough planning and study been put into this reorganization proposal being considered at this hearing today? We have some reservations over the fast track on which this proposal is traveling, as well as the overall reorganization plan.

From a report provided by Veterans Affairs as of July 1, 1996, there are 66,000 veterans residing in the sixteen counties surrounding the Montgomery and Tuskegee Medical Centers. Of this number, 51,130 are wartime veterans, of which over 17,500 are World War I and World War II veterans, and 11,800 are Korean veterans. These veterans are in the age group that are more in need of care to make up almost half—and that is in error, it is more than half of the wartime veterans in this era—area. Also there are over 21,000 who have served in the later conflicts.

Given the rapid pace of change in health care, VHA must adopt a new organizational structure and philosophy. It must become more flexible, responsive, and patient-oriented. The movement to the Veterans Integrated Service Network, VISN, is just one step in the continuous pursuit of a health care system responsive to the needs of veterans. The realignment and reorganization of VA medical facilities is a symptomatic attempt to serve veterans within available resources.

There are various internal and external concerns surrounding the effort to integrate veterans' health care facilities. The integration process assumes a spirit of cooperation among facilities that never historically existed. To be successful, mergers and integrations must be well planned and implemented over a period of several years. Just one moment, please, sir.

Given the rapid pace, there are various internal and external concerns surrounding this effort. Many employees today are uncertain about their government careers. Significant reductions in force, RIFs, are occurring or planned throughout the VAH. It is our belief that this merger/consolidation is occurring too rapidly, thereby causing some degree of confusion and misunderstanding among the VHA work force, the veterans, and the families affected by these two medical centers. Therefore we request that this merger/consolidation be slowed down.

The American Legion of Alabama is concerned that all of the unique problems associated with a rapid merger/integration process have not been resolved. The objectives of having VA medical facilities become more efficient is a common goal to both Congress and The American Legion. When the pace of change is too rapid a danger exists that the quality, the quantity, and the timeliness of care can be compromised.

Some of the following principles put forth by the Undersecretary for Health are to be applied in each proposed merger/consolidation.

A: What are the general and specific goals that are to be achieved by the restructuring?

B: What are the specific outcome measures that will be tracked and what is the process for monitoring those measures that will be used to determine if the goals are achieved.

C: How will quality of care be monitored and maintained or improved?

D: How will patient satisfaction and customer service be monitored and maintained?

And E: How will progress—program costs be evaluated and monitored?

The Department of Alabama American Legion fully agrees with the statement of the Undersecretary of Health that, and I quote, "The importance of being able to clearly answer the above questions cannot be overemphasized. Likewise, the need for full and open discussions with stock—stakeholder groups and employees is of paramount importance," end of quote.

We believe that this entire reorganization should be thoroughly and thoughtfully planned and coordinated with a sensitivity of the employees, veterans, and stakeholders throughout the entire process merger/consolidation procedure. The American Legion believes that the director/manager of the merger/integration process of the Montgomery and Tuskegee medical facilities should be an outsider who has no ties with either hospital. This hopefully will insure impartial decisions on all important transition matters between both facilities.

The transfer of personnel from one facility to another will cause some dissatisfaction and stress on those affected. Every effort should be made to lessen this impact on the work force and the patients. A new director could possibly make this transition a little smoother. We hope that this matter will be given further consideration.

The American Legion supports H.R. 335 as a method of better—to better manage veterans' health care facilities. This legislation would establish the Commission on the Future of America's Veterans. The measure is designed to conduct a comprehensive study of health care services provided by the Department of Veterans Affairs. H.R. 335 will allow VA to take a step back, consolidate its gains, and refocus its future direction.

Mr. Chairman, the main purpose of these proposed changes is to transform the medical care program into a more efficient health care system with less money. We believe that this can be accomplished with proper planning and implementation procedures.

Mr. Chairman, this concludes my statement.

[The prepared statement of Mr. Cooper appears on p. 55.]

Mr. EVERETT. Thank you very much, Mr. Cooper.
Mr. Mosley.

STATEMENT OF THURSTON MOSLEY, STATE COMMANDER, DISABLED AMERICAN VETERANS

Mr. MOSLEY. Mr. Chairman, distinguished members of the Subcommittee on Oversight and Investigations, I want to thank you for giving us this opportunity to give our views on the consolidation of the VA hospitals at Montgomery and Tuskegee.

I am the Commander of Disabled American Veterans, Department of Alabama. I represent over 16,000 card-carrying members, their widows, their widowers, and their orphans. This State has approximately 435,000 veterans; 44,000 who are disabled.

We feel that all veterans' organizations should be represented as shareholders in all aspects of VA planning. Each organization represents a certain elite group of veterans, and each have had an opportunity to speak on behalf of its membership. There are many veterans that do not belong to any of the veterans' organizations, but we give them our support. As we do for one of our own members, we come into contact with them daily, we listen to their complaints, and we take action. We view this effort to exclude us as shareholders as a lessening of medical services to our veterans, a decrease in quality and timeliness.

In consolidating the VA hospitals there will be more travel time involved for many of our older veterans. The World War II veterans who are now 76 years of age are the greatest users of the VA hospitals. In my own personal case I must travel 60 miles from my home to the Montgomery VA Regional Hospital. For me to be sent to Tuskegee I would travel another approximately 42 miles. This is a 200-plus mile round trip for me.

Now, what happens if I am hospitalized in Tuskegee? My family will be called upon to add extra time and extra miles to their visits. My family and all other families of our veterans have sacrificed enough. Because they felt honored to serve their country, our veterans left their families in order to fight for the freedoms that make the United States of America a great and wonderful Nation. War changed these families forever. Men and women both returned less than whole, and many did not return at all.

The Disabled American Veterans, Department of Alabama, and our national office has concurred in a general business plan to improve services at a lower cost, working smarter, and providing better access near our veterans' homes, such as community-based care as in Anniston, and hope to have soon in Dothan. We will never agree with plans that provide less access points of entry for all care. We have always asked for better access, timeliness, and quality of care. This cannot happen if the two hospitals are combined.

Concerning the monies saved by the VA, no one has shown me figures to back up the projected savings. The only savings seem to be the elimination of only having one hospital administrator. Consolidation of the Montgomery VA Regional Hospital and the Tuskegee VA Hospital will simply be putting a burden on the veteran who has already sacrificed much for this great Nation, the United States of America. And stated earlier, Alabama has approximately 435,000 veterans, and of these 44,000 are disabled vet-

erans who left on the battlefields their blood, sweat, tears, eyesight, hearing, minds, and limbs. Furthermore, many gave the ultimate, their lives, leaving behind their loved ones in need of our care.

Mr. Chairman, I urge you and this Committee to stand up for the many veterans that fought on the battlefields for the freedoms of the United States of America. I implore you to terminate this effort to merge these two hospitals for the best interest of the Alabama veterans.

I thank all of you for your time, patience, and consideration of this matter. Thank you.

[The prepared statement of Mr. Mosley appears on p. 60.]

Mr. EVERETT. Sir, thank you very much.

Mr. McKenzie.

STATEMENT OF WILLIAM E. McKENZIE, VIETNAM VETERANS OF AMERICA

Mr. MCKENZIE. Mr. Chairman, I want to thank you very much for the opportunity to address this Committee. And, Mr. Evans, I would like to thank you for your veterans support in Washington, DC, on numerous occasions, and we really do appreciate it as Vietnam veterans. Thank you very much.

I have this statement and I am pretty sure that everybody has it. Our basic concern is—and I guess I represent a totally different generation of veterans than the other organizations here. We are actively employed veterans. We are still in the job markets. We have insurance. Cost recovery is a concern to most Vietnam veterans who carry insurance.

And basically my statement is to why Vietnam veterans who are gainfully employed and hold active and—insurance policies do not participate in VA hospital facilities. The Montgomery VA hospital, over the last 3 or 4 years, have made great strides, and The American Legion 2 years ago conducted a survey and ranked Montgomery's VA hospital as one of the top outpatient clinics in the Nation.

Tuskegee, on the other hand, is way down below this. Our concern is this merger is decreased—will decrease the quality of care, the respect, the attitude of the employees of the Montgomery VA facility. It has already started to affect it. As a patient and a representative at both the hospitals, you know, I just—I feel like that—and the VVA's concern is if you want to push the part of the insurance claims and the Vietnam veterans further away from the department of the government—U.S. government, then go ahead and leave the same management in the same direction that you are going with this merger. Already 40 percent of the Vietnam veterans in this country would not go to a VA hospital for any reason, and you will probably put 30 percent more on top of that that will not go to a VA hospital or facility or a government facility of any kind.

We have worked hard as an organization to communicate to Vietnam veterans that services at VA hospitals are there, and we encourage them to—Vietnam veterans to use VA facilities because the money from the insurance is reimbursed back to the Department of Veterans Affairs. And that is our basic concern. We use these facilities when they are adequate, when they are efficient, and when we do not lose money out of our paycheck.

In my statement, the average time at a Montgomery VA hospital before the merger started—or integration as they want to be called—was about 2 to 3 hours. And personally that costs me about 30 or $40 to go to a VA hospital, which at that time was cheaper than going to an independent or private owned medical facility because of the expediency of the VA hospital on an outpatient clinic basis.

Meanwhile, with an appointment at the Tuskegee VA hospital I have sat in that waiting room at Tuskegee VA hospital outpatient client for 8 hours before even being seen by a doctor. When you question the delays at Tuskegee VA hospital then you are treated with disrespect and you are actually told that it is none of your concern. The problem is not with the care renderers at Tuskegee VA hospital, it is with the people who do the paperwork and the administrative office.

Since the merger started I have been up there on four different occasions and have not been able to find anyone in the administrative office other than the secretary. The passed complaint that I answered through my testimony about the conditions at Building 50——

Mr. EVERETT. Will, if you will, go into detail about that complaint that was forwarded to you by Mr. Max Roberts, my neighbor, who is also the State Council President of the VVA.

Mr. MCKENZIE. Yes, sir.

On Tuesday, June 17, 1997, while looking into a complaint passed to me from the VVA State Council President Mr. Max Roberts, I entered Building 50 around 10 a.m. I was shocked to find the temperature near 100 degrees. The smell of urine was overwhelming. There was not even a fan to move the air.

When I went to Mr. Clay's office I was told that he was not in his office today. I looked and the only person—the only people who were in the office were the office—Excuse me, I am—I am not very good at this. My bifocals are out of adjustment.

But, anyway, the only people who were in the office were secretaries. I looked around for a patient representative; patient representative was not on the grounds. Finally I went to Mr. Moore who is State Department of Veterans Affairs Representative at Tuskegee VA hospital. He referred me to Mrs. Coldman, who is a social worker, who took complaints—who takes complaints, and my complaint was registered, and called engineering and logged a complaint.

Engineering said that their—this was the first they had heard about it and would get right on it. When I went back to Building 50 and was told that the air had not been—I mean had been out for 7 to 9 days. And to add into this, now, Building 50, for all you who are not aware, it is an indigent care facility. These are patients who are not able to move on their own. They are confined to wheelchairs, they are bedridden patients. They require a lot of assistance.

And, anyway, the air conditioning had not been on for 7 to 9 days. They were notified numerous times and no work had been done on the air conditioning. It was 1,500 hours, three o'clock that I spent all day there; no maintenance personnel had shown up at Building 50 to repair the air conditioning.

I returned to Mr. Clay's office and asked to see someone in authority and was told that they was all out of the office. The chief of staff's secretary then called engineering and asked if they would like—if they would—if they were told that the air conditioning in Building 50 was out, a patient was complaining. I was referred to as a patient rather than a representative of a veterans' organization. I told her I was not a patient, but I was a representative of the VVA. When she told the person on the other end of the phone she said, "Mannie, this is not funny. Do you not think we are in enough trouble already?"

And that is the attitude of these people up there. They laugh when you register a complaint. They think it is funny. They are not even—they are not taking our heroes or especially my heroes of World War II and Korean veterans seriously. And it is a travesty.

And then it goes on to say that I called a reporter. We returned to the VA hospital. I had another VVA member go in Wednesday. There was three press releases from the VA hospital that no two were the same on conditions—or reasons why Building 50 were in the State that they are in or was in.

Wednesday—I received a report Wednesday night that they had been working on the air conditioning and all day Wednesday in Building 50. I returned Sunday at the family's request for a visit to the patient. The building was clean, the air conditioning was on. I talked to some of the employees as well as the patients and was—come to find out that the heat had never been turned off in this building. The major excuse for this was Building 50 is one of the buildings that they plan on closing down when they get the new indigent care 120-bed facility built.

But, as I stated before, these indigent care people, they do not have any reason to suffer these conditions. I feel like during World War II and the Korean War they suffered enough. They do not need to have to endure this, especially when they cannot even get out and take care of themselves.

I brought it to the attention about the lady laughing on the telephone to Mr. Clay. I have here a letter that I received from Mr. Clay June the 23rd. Says, "Dear Mr. McKenzie, This is a follow-up on our conversation on Sunday, July the 13th, 1997, at the VAVS meeting concerning irresponsible behavior of the staff member. We investigated the situation and found that when Ms. Smith placed a phone call to the nursing services regarding the air conditioning——"

Mr. EVERETT. Will, did you say nursing services?

Mr. MCKENZIE. Nursing services. Yes, sir. I would be glad to give you a copy of this letter.

"—nursing services regarding the air conditioning situation and the manner that—in which Ms. Smith questioned the staff member made the staff member giggle at her speech."

Now, this lady called engineering. And this is, as Mr. Everett brought forth, from nursing services. This is the type of response that we, as an organization, on our complaints are getting from the staff of Tuskegee VA hospital. We feel like that if this merger——

And we agree that cost-cutting is appropriate. We need an excuse and an effective plan set forward. We do not need administrators

who follow investigations to this extent and do not even read what they are supposed to be looking at.

We feel that the leadership at the Tuskegee VA hospital is highly incompetent. We are totally against the merger due to the reason that we fear that Tuskegee employees will be transferred to Montgomery and depreciate and diminish the quality of the services we, as Vietnam veterans, receive at the Montgomery VA facility.

And thank you very much.

[The prepared statement of Mr. McKenzie appears on p. 62.]

Mr. EVERETT. Thank you very much for your testimony, gentleman. Let me start off by asking each of you if you are satisfied with the confrontation process between the VA and you as stakeholders? And if you will, follow up by adding—telling me how you feel like it could have been improved.

Mr. Cooper, we will start with you, please.

Mr. COOPER. Mr. Chairman, I would like to introduce Mr. Clarence Jacobs who is the immediate past department commander of The American Legion.

Mr. EVERETT. I have seen Mr. Jacobson up in Washington. Good to see you again.

Mr. COOPER. And, Jake, if you will, probably can give you some comments on that.

Mr. JACOBSON. Yes, Congressman.

You know, our organization is entirely—or very much involved and interested in the betterment of the benefits and privileges of veterans. It is our understanding that this merger and consolidation is moving too fast. And what is happening with it, from what I have understood, that the employees have got very much confused. And you know as well as I do if you have got unhappy employees it is going to domino on down to the people that they are affected with, and this in turn is our VA patients.

We do believe in all aspects that the concept of this reorganization is good. However, the manner in which it is being conducted and carried out needs to be looked at. The time factor, we believe, has been too fast, and we do ask that it be slowed down and taken another look at. We believe that this H.R. 335 is the vehicle in order to provide this.

We also believe that it should be new management sought and placed over this merger and integration. It does not—one aspect of it could be that it would not even have to be at either one of the facilities, but maybe a UAB, and have it administered from there to keep both facilities on an equal status.

More input should be provided to the stakeholders and the patients and the work force that are involved in it. We should never lose sight of the main objective, and that is to have an efficient health care system for our veterans. We do not need that to be shuffling around between Tuskegee and Montgomery. If they can be treated in one of the facilities let us keep them there and treat them at that facility, not let them get on a bus or a van and take them to the other facility to be treated. Let us do it at the same facility where they are at. They have got enough hardships as it is. Thank you.

Mr. EVERETT. Thank you very much. Mr. Mosley.

Mr. MOSLEY. Mr. Chairman, you know the VA is a very large organization. I do not think I have ever been but in one larger one and that was when I was in the United States Army. In any large organization you—we are going to have ups and downs. But it appears to me that we are looking at the cost-wise, at the higher echelon, and not considered that little veteran down there that really needs the care.

Now, we say that we are going to cut out doctors and nurses and save money. For example, let us not knock out the care, let us knock out the administrative part. One person—and I have made the statement to Senator Shelby in Washington, that if the government would give me one million dollars and give me the authority to fire anybody I wanted to and let me go around the Federal Government I could balance the budget in 2 years. I honestly believe that.

Mr. EVERETT. You may be right.

Mr. MOSLEY. But we are still putting the burden, we are causing these veterans to travel at a further distance. And it is not just a burden of being tired. You know, 4 hours on the road, and as we get older I have noticed myself the miles were getting longer. I do not know how that works, but the miles get longer.

And what I would—what I think should be done is let us take these veterans, that is why we want to be a part of a shareholder. We want to represent this man out here that is—that is old. Do not put the burden on him. It is burden enough for me to travel back and forth physically, mentally. But we are also putting the burden of him having to pay. It costs him money out of his pocket. And most of these, and myself included, are on a fixed income. And when we start adding to, that means taking away from him.

So there is a lot to be changed and I wish we could snap our fingers, it would all be all right, but that is not the way it works. We are all going to have to work together.

But as the—my comrade over here stated, I think we need more efficient personnel in these supervisor positions. This is our main avenue, our main purpose, to get to them. The supervisor positions, if they are efficient, they will make sure that person that is under them is taking care of that veteran. Thank you.

Mr. EVERETT. Thank you very much. Mr. McKenzie.

Mr. MCKENZIE. I just have one thing to add and it should speak for everyone here concerned. And the Vietnam Veterans of America has a slogan that says, "Never again will one generation of veterans forget another." And that is our intention as an organization. And personally I intend to stand fully behind it. And thank you very much.

Mr. EVERETT. Thank you. Lane, do you have some questions?

Mr. EVANS. Yes, Mr. Chairman. Thank you.

We have heard a lot about the involvement of the stakeholders in this process. And a lot of your concerns that you have just voiced about the pace of the integration process moving ahead. In the last year or so how much has your individual organizations been contacted by the VA, been involved in meetings with other so-called stakeholders and otherwise involved? Can you just kind of give a feel for what your involvement with the VA has been?

Mr. MOSLEY. Not to my knowledge. Now, I will say this in defense of the VA. I was notified this week that we have what we call a Alabama Management Team of the VA which will be working with Mr. Deal. I believe all the commanders from all the service organizations will be working on this. And maybe this is the first step; I do not know. I do not really understand what I am, but I am a member of it. And this may be a step.

Mr. EVANS. Have the individuals here been invited to this upcoming meeting of this organization, which is unclear in its definition at this point, or do you have any comments about your involvement? Sir, would you——

Mr. COOPER. As far as The American Legion is concerned, I am not sure that we had a lot of information directly to us. Some correspondence I have seen just in recent weeks or days that went to our State Department of Veterans Affairs, Mr. Frank Wilkes' office. And that, of course, I suppose, was passed out into some of the communities. But to my knowledge the information that we received—that I received as a past department commander of the Legion, a past national vice commander of the Legion, was very limited. I had very little information about it. Maybe I did not avail myself to some of the information that was available, but I just did not have it; I did not get it.

Mr. EVANS. You seem very concerned about the pace of this process. Is there a case—is it the pace of the individuals dealing with the changes, the stakeholders having to deal with changes that are proposed, or is it just they were not properly coherent in the development of policy for implementation or rushing into the process too quickly as far as the planning?

Mr. COOPER. I know a lot of time and effort has been put into the process already. I realize that, and it is commendable what has been done. But my concern—our concern is, here again, that from information that we have gained or learned, that many of the people affected, employees and of course patient, patient families, probably have not been informed to the extent that maybe they ought to be. Now, that is our concern, and maybe we need a little more time. We referred to H.R. 335. This does form a commission that looks into the total program and then comes up with——

But, anyway, this is our concern, that maybe a little time is needed. I think as far as the integration/merger, as we have stated, we have no strong objections here. But I noticed the date is right away. I am not sure exactly what that date is. October 1997. I do not think we are ready for it.

Mr. EVANS. Was VVA involved at this discussion?

Mr. MCKENZIE. I do not know about being involved in this discussion, but I sat on the advisory committee to the Tuskegee VA hospital. Have quarterly meetings, I have been to luncheons. There is—and that is the extent of the involvement of veterans' organizations in this whole plan. We have not been asked pro, con. We have specific questions, such as Affirmative Action being applied to the job positions that would be created and also eliminated. We have had no response.

Mr. EVANS. What would each individual organization like to see as their role in this process?

Mr. MCKENZIE. We would like to see the quality of the veterans' health care at least improve at Tuskegee VA hospital to the level that it was at the Montgomery VA hospital. That is the least that we, as Vietnam veterans, would be expecting.

Mr. EVANS. Thank you, Mr. Chairman.

Mr. EVERETT. Thank you, Lane.

I certainly appreciate everybody attending here today. I particularly appreciate the attendance of our veterans as those—the organizations that serve our veterans here in Alabama as well.

In closing, I would also like to thank my distinguished colleague, Mr. Evans, for coming to the field hearing and participating in it. Ours, I have to say, is probably the most bipartisan committee in Congress.

And I think that we are very much in agreement on what the necessary planning before the facility consolidation and integration can take place. Today we have heard testimony that clearly indicates there is a great deal more planning and communication with stakeholders necessary before VA is in a position to go forward with the integration of Montgomery and Tuskegee VA Medical Centers.

The objectives are worthy. But the VA has to demonstrate much more persuasively on how to achieve the results that it promises. Now, I want to tell everybody up front the only fairness issue that will be considered in this integration process will be what is fair for the American veteran who served this Nation so well. The only fairness issue that will be considered. I want to be heard on that.

I will keep an open mind, as always. I intend—but as always I intend to put the best interest of the veterans first.

Thank you very much. This hearing is adjourned.

[Whereupon, at 11:45 a.m. the subcommittee was adjourned.]

APPENDIX

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
HONORABLE TERRY EVERETT, CHAIRMAN

FIELD HEARING ON THE PLANNING AND FORMATION OF THE CENTRAL ALABAMA VETERANS HEALTH CARE SYSTEM

Montgomery, Alabama
July 28, 1997

Opening Statement

Hearing will come to order.

Good morning! I want to give a warm welcome to the Alabama veterans and interested members of the Montgomery and Tuskegee communities who are here today for this long anticipated field hearing on the planning and formation of the Central Alabama Veterans Health Care System (CAVHCS). [Pronounced KAY-VAX.]

I am joined by the distinguished Ranking Democratic Member of the full Veterans Affairs Committee, Mr. Lane Evans, from Illinois. He has a major facility integration occurring in his state as well in the Chicago area. Some of his concerns about that integration process are much the same as mine are for Central Alabama. They involve planning issues and communication with stakeholders.

And, by the way, the term "facility integration" means the combining of two or more medical facilities into one functional organization to provide a coordinated continuum of health care to veterans. Here in Alabama, we have under way the planning for the formation of the CAVHCS.

Just last Thursday (July 24, 1997) Mr. Evans and I were at a joint hearing of the Veterans Affairs Subcommittees on Health and on Oversight and Investigations in Washington, DC, on this very subject. As Chairman of the Subcommittee on Oversight and Investigations, I co-chaired that hearing. Mr. Evans and I, as members of the VA Committee with leadership positions, have a constitutional duty to ensure that the laws under the jurisdiction of the Committee are properly carried out by the VA and that veterans receive the benefits Congress has mandated for them. One of the ways we do that is though oversight hearings such as this.

The focus of the hearing in Washington was on the VA's approach to facility integrations generally and on the Chicago VA hospital integration. The head of the VA health care system, Under Secretary Kenneth Kizer, and other VA officials testified at that hearing. The same witnesses from the General Accounting Office we have today also testified last Thursday.

In several respects, that joint hearing laid the foundation for today's hearing. The VA in Washington is still defining its guidance to regional network directors on how the integration process should operate, so it is not surprising that questions have arisen here in Alabama as well.

We are working with the VA to improve health care for veterans by improving the way facility integrations are accomplished. Specific issues have arisen about planning, and the cost-benefit analysis for the Central Alabama facilities, and, frankly, communications with this stakeholder haven't been as good as they should have been. I see a willingness on the part of the VA to improve the process and better address stakeholder concerns, and I hope we can move forward from there in Veterans Integrated Service Network 7, the VA region in which Central Alabama is located.

I have spent much of my adult life as a businessman, and that's how I approach these issues. I want to see a real business plan with the evidence that it is the optimal approach and that it actually will save money and improve efficiency. Moreover, I expect to see a plan for the fair reinvestment of money saved for Alabama's veterans in the form of better access to health care. It is not my intent to try to turn this into "Mission Impossible" and I recognize these are not easy tasks. But the stakes are high and many people in Central Alabama have legitimate interests that concern them greatly.

Because of my concerns, I did ask Dr. Kizer, the Undersecretary for Health, to halt the integration implementation process until my fundamental concerns about planning issues could be addressed. He agreed to do so, and the integration implementation has been halted, but not the planning. Mr. Larry Deal, the VA regional director and VA's lead witness today, subsequently requested that consolidation of the surgery services proceed without delay.

His reasons for wanting to go ahead immediately seemed sound to me, and the consolidation of surgery will be accomplished as soon as possible.

The General Accounting Office, the investigative and audit arm of Congress, has been reviewing the planning process and cost benefit analysis for Central Alabama and will testify today on its findings and suggestions for improvement. Also, several of our veteran service organizations, The American Legion, the Veterans of Foreign Wars, the Disabled American Veterans and Vietnam Veterans of America, who so faithfully represent the veterans of Alabama, will present their views about VA health care for veterans at Montgomery and Tuskegee.

Obviously, while veterans are not the only stakeholders in Central Alabama, they are the most important one. The VA exists because of them. I am certain we have other stakeholders attending this morning, and they are important to me too. Unfortunately, Mr. Evans and I must return to Washington at midday because House votes are scheduled for this evening. Therefore, time constraints do not allow opening up other lines of testimony at this hearing. I welcome all points of view and, if anyone wishes to do so, please call my district office or write to me. Many people have already called and written, and I appreciate their interest.

As the newspapers have reported, I have requested that the VA Inspector General's Office independently investigate certain whistle blower allegations of mismanagement and misconduct at Tuskegee. I took that action as a member of congress with specific oversight responsibilities.

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Of course, I have no way of knowing if any of the allegations are true. The IG's Office has advised me that it will take possibly several months to do a thorough investigation because of the number of allegations. I do not expect to comment further publicly until the IG and the VA have had the opportunity to do their work and draw their own conclusions.

I want to make it clear our hearing today is only about Central Alabama. At this point, nobody is proposing that suggested improvements for this integration process should become a model for the rest of the country or be some sort of a pilot program. I support the overall objectives of the consolidation. It is in the best interests of Alabama's veterans and taxpayers. But it must be done right, so that it improves efficiency, provides quality care and improves access for veterans. It's up to the VA to convince me and our veterans that, based on planning yet to be done, that those will be the outcomes.

Also, one thing I want to make crystal clear is that there is no VA plan or intent to close either Montgomery or Tuskegee. I will confirm that with both the VA and GAO witnesses.

I expect good, efficient management and quality health care for our veterans in each and every VA hospital in the country, and I won't be satisfied with anything less.

And that goes double for our veterans in Alabama.

STATEMENT OF THE HON. LANE EVANS (D-IL)
RANKING DEMOCRATIC MEMBER,
HOUSE COMMITTEE ON VETERANS AFFAIRS

BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS FIELD HEARING ON
THE VA INTEGRATION PLAN AT MONTGOMERY AND TUSKEGEE, ALABAMA FACILITIES

July 28, 1997

Good morning, Mr. Chairman. I want to thank you for holding this timely hearing today. You should be commended for your leadership on this issue.

As the Chairman of the Oversight and Investigations Subcommittee, you are a strong advocate for the view that any plans to integrate or consolidate VA facilities must only be carried out with comprehensive planning and the utmost of care. I share your concerns, and commend you for taking the time and effort to bring Congress to Montgomery for a few hours this morning to discuss the integration process in Tuskegee and Montgomery, Alabama.

The witnesses scheduled to testify will focus on the process by which VA has begun its integration efforts at Tuskegee and Montgomery. It is my hope that we can acquire some "lessons learned" from this hearing to improve the integration process both here in Alabama and across the country.

There are clearly some benefits to be gained by integrating some VHA activities and facilities. In our current funding environment, I believe we cannot overlook opportunities for cost savings if we can achieve such an end while improving health care service to our deserving veterans. The VA needs to provide leadership to the process, however, and it must be able to spell out the tangible benefits to our veterans before the integration process begins.

I believe the involvement of veterans, academic affiliates, employee unions and other partners is critical to the successful planning and managing of the integration process. Outreach between the VA and its various stakeholders must not end when Chairman Everett's gavel brings this hearing to a close.

Thank you again Mr. Everett for your leadership on this issue. look forward to the testimony we will hear this morning.

STATEMENT OF

Mr. Larry R. Deal

Director Veterans Integrated Service Network 7

before the

Subcommittee on Oversight and Investigations

Committee on Veterans Affairs

U.S. House of Representatives

July 28, 1997

Mr. Chairman, Committee Members, fellow veterans and guests. I appreciate this opportunity to update you on the integration of the Montgomery and Tuskegee VA Medical Centers. I would like to discuss three key points involving this integration:

(1) The integration of these facilities will improve the quality, access and cost effectiveness of health care for veterans.

(2) The integration will help improve the long-term viability of both the Montgomery and Tuskegee Medical Centers.

(3) The integration efforts at the Central Alabama Veterans Health Care System are in keeping with

Dr. Kizer's "Vision for Change" and "Prescription for Change".

I believe the integration will highlight the clinical strengths at each facility and improve the quality of care at both in the process. For example, Montgomery's greatest strength is the delivery of acute inpatient services and Tuskegee's greatest strength is the delivery of intermediate and long-term care services. Currently, both facilities are experiencing a significant decline in acute inpatient services with Montgomery experiencing an acute medicine average daily census of less than 50 patients. By moving acute inpatient services from Tuskegee to Montgomery, our veteran patients will receive the benefit of a state-of-the-art acute care facility in Montgomery and improved quality of care as a result of better distribution of staff. Similarly, by consolidating all intermediate and long-term care at Tuskegee, our veterans will benefit from modern facilities, better staffing and expertise in intermediate and long-term care, as well as a new 120 bed nursing home to be activated this fall. The surgical services currently being offered would also

be greatly improved by the integration. A report from the VA's Medical Inspector suggested that the quality of surgery at Montgomery could be greatly improved by consolidation to increase the surgical workload. The increased surgical workload will allow the surgical teams to maintain their skill levels by experiencing a greater variety and volume of cases. The result would be improved quality and eventually increased cost effectiveness.

Improved primary care access at both facilities will be funded from the savings emanating from integrating these two facilities. The Medical Inspector's Report was critical of what they perceived to be an inordinately high ratio of administrative staff to clinical staff at Montgomery. We believe that the integration will help eliminate unnecessary administrative and leadership positions at both facilities thereby freeing up more resources for direct patient care. These dollars can be used to fund improved primary care access by opening community based clinics such as the one scheduled to open in Dothan later this fall.

There has been concern expressed by stakeholders at both Montgomery and Tuskegee that the integration will result in the eventual takeover by one facility, resulting in the closure of the other. In fact, I believe that the integration of these facilities will help to improve the long-term viability of both facilities. The integration will help to improve Montgomery's inpatient acute care census and the quality and viability of it's surgical program. The integration also strengthens Tuskegee's intermediate and long-term care programs. The result is increased quality and utilization of both facilities and much improved cost effectiveness.

The integration of the Montgomery and Tuskegee VA Medical Centers is in keeping with Dr. Kizer's "Vision for Change" and "Prescription for Change". These documents articulate the need for VHA to radically transform the nature of the organizational structure, the health care delivery systems and, perhaps most importantly, the corporate culture of VHA. If the VHA is to remain viable into the 21st century, we clearly must take bold efforts to improve the quality of care, customer service, access and cost effectiveness of our

services. The changes that we must make will be difficult. The changes that will occur at Montgomery and Tuskegee, and indeed throughout the VA, will produce understandable anxiety and, no doubt, some resistance from key stakeholders, especially our veteran patients and employees. There are some who do not want any changes in the way veterans' health care has been historically provided. However, in my opinion, that expectation is unrealistic given veteran demographic trends, fiscal realities, advances in medical technology and the changes occurring throughout the nation in health care delivery.

We began the initial planning for the integration of these two facilities over one year ago. At that time, there was very little experience concerning the best process for planning an integration. Indeed, I am not aware of a template used in the private sector for such mergers or integrations. The reason is that each integration involves a unique mix of clinical programs, demographic, geographic, social, economic and cultural issues. Our planning efforts, while clearly not perfect, were an attempt to involve employees and other stakeholders from both facilities in a "grass

roots" process to design the organizational structure of the integrated facility. It was hoped that this process would not only lead to a better design but to improved communication and "buy-in." A large number of employees and other stakeholders at both facilities devoted hundreds of hours producing outstanding planning documents to guide us through this integration effort. These employees developed a plan designed to maintain a fair balance of jobs being shifted between facilities. I want to publicly thank them for their hard work and dedication to America's veterans.

Congressman Everett, I would like to thank you for your interest in America's veterans. Through the collective efforts of your sub-committee staff, the General Accounting Office (GAO) and VA staff, we have made strides toward enhanced communication and stakeholder involvement resulting in an improved integration planning process. I accept personal responsibility for any shortcomings in the integration planning process or in failing to adequately communicate with our stakeholders.

In summary, I believe in the long-term, this integration will be in the best interest of veterans, employees and the American taxpayers.

Thank you for the opportunity to discuss this matter and for your interest in America's veterans.

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs
House of Representatives

For Release on Delivery
Expected at 9:00 a.m. CDT
Monday, July 28, 1997

VA HEALTH CARE

Opportunities to Enhance Montgomery and Tuskegee Service Integration

Statement of Stephen P. Backhus, Director
Veterans' Affairs and Military Health Care Issues
Health, Education, and Human Services Division

GAO/T-HEHS-97-191

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss our ongoing work on the integration of medical facilities operated by the Department of Veterans Affairs (VA) in Tuskegee and Montgomery. The two facilities' managerial, clinical, and patient support services are to be restructured into a single health care delivery system called the Central Alabama Veterans Health Care System. The system is to provide the same or higher quality services at lower costs; savings are to be reinvested to further enhance veterans' health care.

The Montgomery and Tuskegee integration is a major initiative under way in VA's Atlanta network–one of 22 networks that VA created 2 years ago to help improve the delivery of health care services to our nation's veterans. The Atlanta network operates 1(hospitals and 9 freestanding outpatient clinics, which served over 160,000 veterans at a cost of $782 million in fiscal year 1997. This integration is the only one currently under way in the Atlanta network; other networks have initiated facility integrations in 18 geographic locations nationwide.

We have been monitoring different aspects of the 22 networks' operating policies, procedures, and practices since their inception. Because of your concerns about the impact of possible service changes that the Montgomery and Tuskegee integration may have on veterans, employees, and others, we began to collect information on the integration of these facilities about 3 months ago. Specifically, you asked us to assess th progress of VA's integration planning for these two facilities.

On May 5, we accompanied Chairman Everett on a visit to the two facilities. During that visit, officials from VA's Atlanta network as well as from the Montgomery and Tuskegee facilities told us that they were beginning to implement changes. In general, the officials described several ways that service delivery at the two facilities is to be restructured, including

- unifying management by creating a single team instead of using separate management teams at each facility;
- consolidating clinical services, such as inpatient medicine and surgery, by moving all acute-care patients to the Montgomery facility rather than continuing to provid the service at both facilities;
- centralizing administrative services, such as engineering, by moving most employees to the Tuskegee facility; and
- reengineering some services, such as social work and nursing, by designing more efficient and effective ways to meet veterans' needs.

During this visit, however, VA officials were not prepared to provide detailed information about their proposed service changes. Since then, we have discussed the integration of the facilities with officials in VA's headquarters, Atlanta network, and Montgomery and Tuskegee facilities, and reviewed planning documents. We also discussed integration issues with several private health care providers and consulting firms.

On the basis of our work to date, it appears that both Atlanta network and Montgomery and Tuskegee facility officials have made a lot of progress in planning for this integration, and benefits have already been realized. Planning activities, however, are yet to be completed, including (1) making key decisions on whether and how to restructure certain services, such as nutrition and food services; (2) fully assessing the probable impact of clinical, administrative, and patient support service changes on veterans and employees; and (3) determining how savings will be reinvested to benefit veterans. Moreover, some stakeholders have found it difficult, if not impossible, to assess the reasonableness of VA's decisions and to ultimately "buy in" to them without the benefit of information from completed planning activities facilitywide. Because integrating facilities involves inherently difficult issues and requires careful planning, it seems important for VA to complete its planning in sufficient detail to ensure that benefits are maximized and adverse impacts minimized.

FACILITY INTEGRATIONS PLAY A KEY ROLE IN RESHAPING VA'S HEALTH CARE DELIVERY

Facility integrations are part of VA's nationwide strategy to restructure its health care delivery system to improve access to and quality and efficiency of care provided to our nation's veterans. This is being done in a way that reflects, in large part, changes that have been under way in the private sector for some time. Profound changes in health care brought about by technological advances and the rise of managed health care, among other things, have caused a dramatic shift away from inpatient care and a corresponding increase to outpatient care. Toward this end, VA has been increasing the number of ambulatory care access points, emphasizing primary care, decentralizing decision-making, and integrating facilities to provide an interdependent, interlocking system of care.

Integrations can provide significant benefits to veterans primarily because VA can reinvest the money it saves to further enhance veterans' access and improve service availability and quality. VA estimates that integration of facilities nationwide has generated over $83 million in annual savings, which has been used, in part, to (1) provide new community-based clinics that expand veterans' access to primary care, (2) offer new services at existing medical facilities, and (3) make existing services more accessible through longer operating hours or shorter waiting times. VA expects the Montgomery and Tuskegee integration to save several million dollars annually, and expects to reinvest part of these savings to establish and operate an outpatient clinic in Dothan.

While integrating health care facilities can be beneficial, it requires careful planning because it affects veterans as well as other stakeholders, including VA employees and residents of local communities. For example, facility integrations may alter the way veterans receive VA health care. Historically, many VA facilities afforded veterans one-stop service delivery; that is, they provided as many services as possible at a single location. When inpatient medicine and surgery services are consolidated at the Montgomery facility, veterans will receive primary care at Tuskegee and will have to use Montgomery when they need a hospital admission. These changes will generally bring VA service delivery practices more in line with private sector practices.

Integration of VA medical facilities also has significant impacts on VA employees. Most savings are achieved by reducing the number of employees providing the same services at multiple medical facilities within the same geographic service area. Nationwide, VA has been able, for the most part, to accomplish this reduction through buyouts and routine attrition, although some reductions-in-force were or will be used. Also, in some situations, employees have been moved from one medical facility to another or transferred to different positions within their current medical facility, which in some cases required retraining. Like other integrations, VA has used buyouts and attrition to reduce the Montgomery and Tuskegee workforce by over 100 employees since beginning integration planning. VA officials expect that additional integration planning decisions will be made that will further reduce the workforce and affect other employees by requiring them to be retrained for other positions.

COMPLETING PLANNING PHASE BEFORE IMPLEMENTING CHANGES

VA's integration planning approach has many positive features. For example, the Montgomery and Tuskegee facilities currently plan and implement their integrations using work groups composed of both facilities' employees. Involvement of local facility employees in planning activities appears beneficial in that it expedites the process, includes those most familiar with the operations of each facility, and permits stakeholder involvement in the outcome.

But our work to date also raises concerns about VA's integration planning process. Integration decisions are generally made incrementally, that is, on a service-by-service basis, at varying times throughout the process. Also, planning and implementation activities frequently occur simultaneously, without a detailed comprehensive plan.

By contrast, private health care providers and consulting firms with whom we spoke appear to approach integrations with a more structured process that places greater emphasis on reaching implementation decisions after comprehensive integration planning is completed. Providers generally told us that they prepare written plans that include detailed analyses of services at each facility, how services can best be restructured, and how the changes will affect patients, employees, and others.

VA's process contains one common decision point–headquarters approval of an initial integration proposal before detailed planning begins. With the September 10, 1996, approval of the Montgomery and Tuskegee integration proposal, VA decided to operate the two facilities as an integrated health care system using a single management team. Following this decision, a governing board was established to direct and oversee the integration planning process. The board established 13 work groups to analyze data and explore integration options. These groups then submitted their integration proposals to the board, and subsequently, the network office authorized the implementation phase of the integration. Soon after, the director of the newly integrated facilities established four task forces to analyze in more detail certain aspects of the proposals, including space and relocation requirements. The director has the authority to implement changes on a service-by-service basis as he determines appropriate.

This incremental approach runs the risk that later work group proposals could affect previously implemented actions or, conversely, may be limited by proposals that have already been implemented. In addition, it is almost impossible to determine the reasonableness of VA's decisions when they are made incrementally.

For example, the cornerstone of the Montgomery and Tuskegee integration is the consolidation of acute care at Montgomery and long-term, rehabilitative, and psychiatric care at Tuskegee. In addition, administrative services are to be centralized at Tuskegee. This decision to relocate administrative staff now employed at the Montgomery facility was based on (1) a determination that there would not be sufficient space available for the administrative staff at Montgomery once acute care was moved there and (2) a perception that this would be fair to Tuskegee because acute care was being moved to Montgomery. However, the decision was made without adequately (1) exploring other options that could alleviate the space concern, such as relocating the staff in other buildings on the Montgomery campus, or (2) taking into account how future changes in workload might affect the availability of space in Montgomery, in which case it might be more prudent for VA to lease space nearby until space becomes available at the Montgomery facility.

Also, because VA had not yet made decisions on how to integrate a number of other services before implementation, some key questions about the availability of space in Montgomery remained unanswered. VA is still considering, for instance, several options for restructuring the nutrition and food service, which could make more space available at Montgomery. For example, one option is to consolidate food preparation at one facility and transport meals to the other. Another option is to contract for services. Selecting one of these options could help avoid the costs of moving administrative employees to Tuskegee. Consequently, without a decision on these options, VA has a limited basis for knowing whether its overall integration decisions will produce optimal results.

PROVIDING A DETAILED INTEGRATION PLAN TO STAKEHOLDERS BEFORE IMPLEMENTATION BEGINS

Stakeholders' participation in the process, and ultimately their buy-in, could be enhanced if VA provided them detailed information on all aspects of the integration before beginning implementation. Several private providers told us that before implementing integration changes, they provide stakeholders information such as services to be integrated and resources required. VA does encourage local facilities to have early and continued stakeholder involvement in the integration process.

While the Montgomery and Tuskegee facilities have worked hard to involve stakeholders by using such techniques as meetings, letters, briefings, and newsletters, some of VA's integration actions are difficult to understand because insufficient information about the integration is currently available, such as

- how services will be integrated,
- how potential changes will affect veterans and employees,
- why selected alternatives are the best ones available,
- how much the potential changes will cost to implement,
- how much the potential changes will save, and
- how VA will reinvest savings to benefit veterans.

For example, VA's inability to provide sufficient information raised concerns about VA's decision to centralize administrative services at Tuskegee. VA made this decision before determining how many or which employees would be moved and, as discussed earlier, without weighing other options that could affect the need to move administrative staff. Therefore, VA officials could not answer some important questions about the potential impact of this proposed action.

In addition, VA officials' failure to consider all potential construction and renovation costs needed for the two facilities over the next several years raises questions. Estimates presented by the work groups to the board showed that integration renovation costs would be about $300,000, including over $100,000 to renovate the Tuskegee buildings that would house the administrative staff. But a master construction plan discussed at the same board meeting showed that estimated construction costs for the two facilities over the next few years could approach $8 million, including other possible renovation costs t house administrative staff. VA officials said they do not consider this plan to be part of the integration because they believe that many of the projects in it would be done regardless of whether the facilities are integrated. We believe that VA should consider al

potential expenditures for the two facilities over the next several years as integration-related decisions so that it can better demonstrate to stakeholders the reasonableness of the renovation costs as they relate to the overall plan for the integration.

VA's incremental planning approach contributes to communication problems because it limits the amount of information available about the integration before implementation begins. Providing this information would enable VA to communicate more effectively with stakeholders. Moreover, presenting such planning results in a written document that could be shared with stakeholders would further enhance the opportunity for effective communication by allowing VA to obtain stakeholders' views and gain support or buy-in for its proposed integration activities.

VA is currently considering ways to improve its integration planning and implementation process. Toward this end, VA is developing a more structured process that should increase the availability of information at important decision points. However, our work to date suggests that stakeholders' interests may be better served if VA completed a comprehensive planning phase and achieved buy in from those stakeholders before implementation.

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This concludes my prepared statement. I will be glad to answer any questions you or Members of the Subcommittee may have.

STATEMENT OF ANDREW COOPER
PAST COMMANDER
DEPARTMENT OF ALABAMA
AMERICAN LEGION
BEFORE A HEARING OF
THE VETERANS AFFAIRS SUBCOMMITTEE
FOR OVERSIGHT AND INVESTIGATIONS

JULY 28, 1997

Mr. Chairman and Distinguished Members of the Subcommittee:

We welcome the occasion as a "stakeholder" of the VA medical system to offer a perspective on the reorganized Veterans Health Administration (VHA).

The American Legion, Department of Alabama, appreciates the opportunity to communicate its viewpoints on the Department of Veterans Affairs (VA) proposed merger/integration of VA medical facilities in central Alabama. In concept, The American Legion, Department of Alabama, supports the planned reorganization of Veterans Health Care facilities, but has enough planning and study been put into this reorganization proposal being considered at this hearing today? We have some reservations over the "fast track" on which this proposal is traveling, as well as the overall reorganization plan.

From a report provided by Veterans Affairs, as of July 1, 1996, there are over 66,000 veterans residing in the 16 counties

surrounding the Montgomery and Tuskegee medical centers. Of this number, 51,130 are wartime veterans, of which over 17,500 are World War I and II veterans and 11,800 are Korean veterans. These veterans are in the age group that are more in need of care and make up almost half of the wartime veterans in this area. Also there are over 21,000 who have served in the later conflicts.

Given the rapid pace of change in health care, VHA must adopt a new organizational structure and philosophy. It must become more flexible, responsive and patient-oriented. The movement to the Veterans Integrated Service Network (VISN) is just one step in the continuous pursuit of a health care system responsive to the needs of veterans. The realignment and reorganization of VA medical facilities is a systematic attempt to serve veterans within available resources.

There are various internal and external concerns surrounding the effort to integrate Veterans Health Care facilities. The integration process assumes a spirit of cooperation among facilities that never historically existed. To be successful, mergers and integrations must be well planned and implemented over a period of several years.

Many VHA employees today are uncertain about their government careers. Significant reductions-in-force (RIFs) are occurring or planned throughout the VHA. It is our believe that this merger/consolidation is occurring too rapidly, thereby causing some degree of confusion and misunderstanding among the VHA work force, the veterans and the families affected with these two

VA medical centers. Therefore, we request that this merger/consolidation be slowed down.

The American Legion in Alabama is concerned that all of the unique problems associated with the rapid merger/integration process have not been resolved. The objectives of having VA Medical facilities become more efficient is a common goal to both Congress and the American Legion. When the pace of change is too rapid, a danger exists that the quality, quantity, and timeliness of care can be compromised.

Some of the following principals put forth by the Under Secretary for Health are to be applied in each proposed merger/consolidation:

a. What are the general and specific goals that are to be achieved by the restructuring?

b. What are the specific outcome measures that will be tracked, and what is the process for monitoring those measures that will be used to determine if the goals are achieved?

c. How will quality of care be monitored and maintained or improved?

d. How will patient satisfaction and customer service be monitored and maintained or improved?

e. How will program costs be evaluated and monitored?

The Department of Alabama American Legion fully agrees with the statement of the Under Secretary of Health that "The importance of being able to clearly answer the above questions cannot be over emphasized. Likewise, the need for full and open discussion with stakeholder groups and employees is of paramount importance". We believe that this entire reorganization should be thoroughly and thoughtfully planned and coordinated with the sensitivity of the employees, veterans and stakeholders throughout this entire process merger/consolidation procedure.

The American Legion believes that the Director/Manager of the merger/integration process of the Montgomery and Tuskegee medical facilities should be an outsider who has no ties with either hospital. This hopefully would insure impartial decisions on all important transition matters between both facilities.

The transfer of personnel from one facility to another will cause some dissatisfaction and stress on those affected. Every effort should be made to lessen this impact on the work force and the patients. A new Director could possibly make this transition a little smoother. We hope that this matter will be given further consideration.

The American Legion supports H.R. 335 as a method to better manage Veterans health care facilities. This legislation would establish the Commission on The Future for American's Veterans. The measure is designed to conduct a comprehensive study of

heath care services provided by the Department of Veterans Affairs.

H.R. 335 will allow VA to take a step back, consolidate its gains, and refocus its future direction.

Mr. Chairman, the main purpose of these proposed changes is to "transform the VA Medical Care program into a more efficient patient health care system", with less money. We believe that this can be accomplished with proper planning and implementation procedures.

Mr. Chairman, that concludes my statement.

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DISABLED AMERICAN VETERANS

DEPARTMENT OF ALABAMA

July 28, 1997

Mr. Chairman, Distinguished members of the Sub-Committee on Oversight and Investigations.

I thank you for this opportunity to give our views on the consolidation of Va Hospitals at Montgomery and Tuskegee. I am the Commander of Disabled American Veterans, Department of Alabama, and I represent over 16,000 card carrying members, their widowers, their widows, and their orphans. This State has appox. 435,000 veterans; 44,000 who are disabled.

(1) We feel that all Veteran's organizations should be represented as *shareholders* in all aspects of VA planning. Each organization represents a certain elite group of veterans, and *each* should have the opportunity to speak on behalf of its membership. There are many veterans that do not belong to any of the veteran' organizations, but we give them our support. As we do for one of our own members, we come into contact with them daily, we listen to their complaints, and we take action. We view this effort to exclude us from shareholders as a lessening of medical services to our veterans—a decrease in *quality* and *timeliness* .

(2) In consolidating the VA Hospitals, there will be more travel time involved for many of our older veterans—the WWII veterans who are now 76 years of age are the greatest users of the VA Hospitals. In my own case, I must travel approximately 60 miles from my home to the Montgomery VA Regional Hospital. For me to be sent to Tuskegee, I would travel another 42 miles.This is a 200 plus miles round trip for me. Now, what happens if I am hospitalized in Tuskegee? My family will be called upon to add extra time and extra miles to their visits. *My family and all other families of our veterans have sacrificed enough.* Because they felt honored to service their county, our veterans left their families in order to fight for the freedoms that make the United States of America a great and wonderful Nation. War changed these families forever—men and women returned less than whole, and many did not return at all.

(3) The DAV, Department of Alabama and our National Office has concurred in a general business plan to improve services at a lower cost—working smarter, and providing better access near our veteran's homes; such as community based care as in Anniston and hope to have in Dothan. We will never agree with plans that provide less access points of entry for all care. We have always asked for better access, timeliness, and quality of care. This cannot happen if the two hospitals are combined.

(4) Concerning the monies saved by the VA, no one has shown me figures to back up the projected savings.The only savings seem to be the elimination of one Hospital Administrator.

Consolidation of the Montgomery VA Regional Hospital and the Tuskegee Va Hospital will simply be putting a burden on the Veteran who has already sacrificed much for this great nation, the United States of America. As stated earlier, Alabama has approx. 435,000 veterans, and of these, 44,000 are disabled veterans who left on the battlefields their blood, sweat, tears, eyesight, hearing, minds, limbs. Furthermore, many gave the ultimate—their lives; leaving behind their loved ones in need of our care.

Mr. Chairman, I urge you and this committee to stand up for the many veterans that fought on the battlefields for the freedoms of the United States of America. I implore you to terminate this effort to merge these two hospitals for the best interest of the Alabama veterans.

I thank all of you for your time, patience, and consideration of this matter.

Sincerely,

Thurston Mosley

STATEMENT OF WILLIAM E. McKENZIE
Vietnam Veterans of America

My name is William McKenzie. I am a Vietnam veteran and a member of the Vietnam Veterans of America, Inc. As a charter member of V.V.A. Chapter 607, I have served three years as president and I am currently Chairman of the Public and Governmental Affairs Committee. It is with the utmost gratitude and sincerity that I come here today to express my concerns, and those of my fellow veterans, over the impending merger of the Tuskegee and Montgomery Medical Centers.

It is apparent to me, after dealing with these two veteran's hospital's, as both a patient and as a representative of the Vietnam Veterans of America, that the quality of service at the Montgomery Hospital by far exceeds that offered at the center in Tuskegee, Alabama. It is my fear that the integration of these two hospitals will lead to a decline in the quality of service offered at the Montgomery Medical Center.

At the Montgomery V. A. facility, a patient can be seen by a doctor, have tests run, and prescriptions filled in a timely and courteous manner. An average visit is two to three hours. It is a different story, however, at Tuskegee. It is not unusual to wait as long as eight hours for treatment at the hospital. Any questions concerning the poor service are answered with disrespect. I have learned that it is wise to stay informed of the danger of drug interaction when taking more than one type of medicine, rather than depending on the doctors at Tuskegee to make the right decisions. On one occasion, after informing a doctor that I was taking Cafergot for migraine headaches, I was given a prescription for Ampicillin. The combination of these two medicines is often fatal. When I called concerning this error, the doctor would not speak to me, and I was told by a nurse that if I didn't want to take the medicine, that it was my problem.

I have visited the Tuskegee Hospital several times since the merger started and have been unable to find a director in the hospital. It seems that the secretaries are in charge on most occasions. I also feel that services at Montgomery have started to decline with the transfer of personnel from Tuskegee to Montgomery. It is my hope that with the proper guidance by the staff in Montgomery, that the employees from Tuskegee will learn to value those who have made sacrifices for their freedom.

As the V.V.A. slogan says, "Never again will one generation of veterans forget another".

With utmost respect,

(ORIGINAL SIGNATURE ON FILE)

William E. McKenzie

V.A. Chapter 607, Public and Government Affairs

ENCLOSURE: (attached is a copy of a report I submitted to the Al. State Council V.V.A. in response to a complaint I received.)

On Tuesday, June 17, 1997, while looking into a complaint passed to me from V.V.A. State Council President Mr. Max Roberts, I entered Building 50 around 10:00 a.m. I was shocked to find the temperature near 100 degrees and the smell of urine to be overwhelming, there was not even a fan to move the air. When I went to Mr. Clay's office, I was told that he was not in the office today. I looked and the only people who were in the office were secretaries. I went to the Patient Representative's office only to find a note stating that they were out for the rest of the week. After asking at least 5 people, who passed me from person to person, I asked to see Mr. Moore, S.D.V.A. Representative, and was put in touch with Mrs. Coldman, a Social Worker, who took complaints, (my complaint), and called Engineering and logged the complaint. Engineering said that this was the first they had heard about it and would get right on it. I went back to Building 50 and was told that the air had been out for 7 to 9 days and that Engineering was notified at once but had not worked on it as of then. It was 1500 hours, and I had not seen Engineering as of yet, so I went back to Mr. Clay's office and asked to see someone in authority and was told they were all out of the office. The Chief of Staff's Secretary then called Engineering and asked if they were told that the air was out in building 50, a patient was there complaining. I told her I was not a patient, but that I was a representative of the V.V.A. When she told the person on the phone that, she said, "Mannie, this is not funny. Don't you think we are in enough trouble already." When I left, I was irate, to say the least. After I got home, I called the paper and told a reporter what shape the place was in. The next day I was interviewed and it went out to A. P. My wife said the phone lit up with calls from D.C. Congressman Terry Everett and two other Congressmen had called. I was asked to meet the family of Mrs. Sean Hughes on Saturday morning. When I arrived at building 50, it was cool and clean and the staff was real nice. We were also told that the heat had never been turned off since winter, even though it had been requested many times by the workers.

(ORIGINAL SIGNATURE ON FILE)

WILLIAM E. MCKENZIE

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